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Department of Health and Social Services

MISSIONS AND MEASURES

Presentation to

House Finance

January 22, 2002

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INTRODUCTION TO DEPARTMENT

Mission

To promote and protect the health and well being of Alaskans.

The Department of Health and Social Services was originally established in 1919 as the Alaska Territorial Health Department. It was established primarily to control diseases and epidemics. The Department continues today to emphasize public health, public welfare and public protection. These core principles are reflected in the mission of the Department (to promote and protect the health and well being of Alaskans) and stem from Article 7, Sections 4 and 5 of the Constitution of the State of Alaska.

In order to carry out our mission, program support is offered in the following areas:

Safety Net Services to Poor, Disabled, and Elderly

- Health Coverage for the Poor: DHSS provides health coverage for the poor with the Medicaid, Denali KidCare, and CAMA programs.

- Cash Based Assistance: DHSS provides cash payments through the Alaska Temporary Assistance Program (Welfare to Work) and Adult Public Assistance Program (monthly cash assistance for poor elderly, blind and disabled).

- Other Assistance programs: DHSS manages the federal food stamp program, Women, Infants and Children (WIC) and Low Income Heating Assistance (LIHEAP) programs that provide food and heating assistance for the poor and disadvantaged.

Protecting Alaskans

- Child Protection Services: Services include investigation, emergency placement, foster care, adoption assistance, residential care and family preservation.

- Juvenile Justice System: DHSS manages the State's juvenile justice system and currently operates seven detention/treatment facilities.

Public Health

- Protection of Public Health: A variety of public health services are managed and provided by DHSS including: Public Health Nursing Services, Epidemiology, Laboratory, Emergency Medical Services and community health services. An important element

Mental Health Beneficiaries

- Alcohol and Drug Abuse Services: DHSS operates through grants to non-profits a wide variety of services to combat alcohol and drug abuse in the state.

- Services for the Mentally Ill & those with Developmental Disabilities: Grants are provided to non-profit entities that provide services in the community for those with mental illness or developmental disabilities. DHSS operates API, the State Psychiatric Institute.

In carrying out these services, we provide the following:

- Benefit payments to 90,000 individuals per month (includes Medicaid eligibility).

- Health Coverage for over 118,000 eligible beneficiaries.

- Over 2,400 positions, of which approximately 1,500 are direct field workers including an estimated [illegible]50 Public Health Nurses, 281 Social Workers, 307 Eligibility/Work Services 270 staff at Alaska Psychiatric Institute (API), 243 Youth Detention/Treatment workers, and 105 Juvenile Probation workers.

- Management of 38 state-owned facilities and 80 leased facilities in over 100 communities in Alaska.

- Management of $137.5 million in grants to communities and non-profit entities throughout Alaska, which provide local jobs to over 2,390 individuals.

- Oversight of over $600 million in federal funds, which flow through the department on an annual basis every year.

To provide these services with a high level of performance, the Department is organized into eight different divisions:

Division of Public Assistance

Division of Medical Assistance

Division of Family and Youth Services

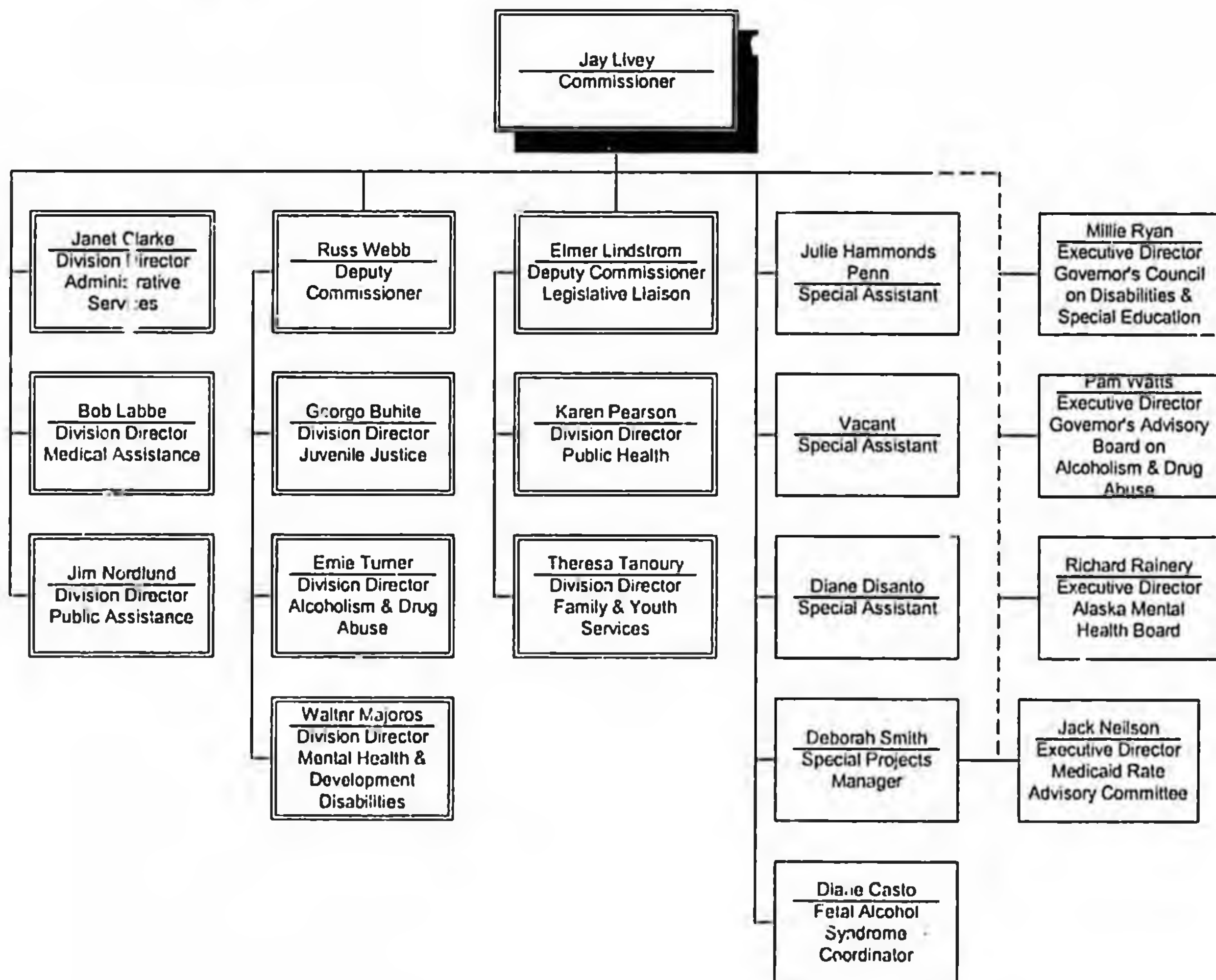
Division of Juvenile Justice

Division of Public Health

Division of Mental Health and Developmental Disabilities

Division of Alcohol and Drug Abuse

Division of Administrative Services



Major Department Accomplishments for FY2001

- To provide better service to the public and meet emerging needs in public health, opened the new Alaska Public Health Laboratory and Office of the State Medical Examiner in Anchorage in January, 2001. Tested scores of samples for anthrax at Alaska Public Health Laboratory, rather than sending them Outside for testing as would previously have been necessary.

- Worked with federal, state, and private contributors to fund Phase 1 of the Code Blue project, which will provide emergency medical services equipment and training in rural Alaska.

- Continued an aggressive immunization campaign to vaccinate all school children and those in day care to meet new requirements.

- Increased the documented Early Periodic Screening Diagnosis and Treatment screening rate from 36% of eligible children to 68% in the current report year.

- Obtained changes to Temporary Assistance Program with federal law exempting Alaska Native villages with high unemployment from the five-year limit; exempting two-parent families with severely disabled children from seasonal benefit cuts; and allowing for uniform application of seasonal two-parent benefits cuts in response to a court decision.

- Alaska ranked 8th in the nation for the percentage of adults in unsubsidized employment and in the average number of hours for adults in unsubsidized employment. Only one state ranked higher in both of these critical measures of welfare reform success.

- The Temporary Assistance for Needy Families caseload declined to 7,421 families in 2001. The average Temporary Assistance caseload was 39% below FY1997, the year before welfare reform was implemented.

- Provided Medicaid coverage through FY2003 for treatment of eligible women who have been diagnosed with breast or cervical cancer.

- Increased efficiencies and streamlined programs and services by consolidating several DHSS offices into the Frontier Building in Anchorage.

- Established a Suicide Prevention Council in statute, with responsibility to develop a statewide suicide prevention plan.

- Began the design-build process to replace the worn-out Alaska Psychiatric Institute facility.

- Through 60+ grantee agencies and an array of for-profit services, provided mental health services to over 20,000 people suffering from mental illness or severe emotional dysfunction.

- Eliminated the Infant Learning Program waiting list.

- The Subsidized Adoption and Guardianship program, which provides permanent homes for children who have been placed in the State's permanent custody, has been very successful. From FY1992 to FY2001, the number of children removed from the foster care system and placed in a permanent home increased 348%, from 338 to 1,515.

- Through the Balloon Project (which provides funding for DFYS and partner legal agencies to focus on moving children on the "transition list" from the foster care system into permanent homes), reduced the growth of the foster parent caseload. In FY1999, the caseload increased by 16.4%; in FY2001, it decreased only 6.2%.

- Provided more thorough training to new child protection social workers through a joint project with the University of Alaska called the Family and Youth Services Training Academy. Approximately 73 new workers completed the primary two-week training course in FY2001.

- Worked with incarcerated kids to provide thousands of community service hours to various agencies and organizations.

- Collected about $20,000 for the Alaska Children's Trust fund through the sale of heirloom birth certificates. Heirloom marriage certificates went on sale in the fall.

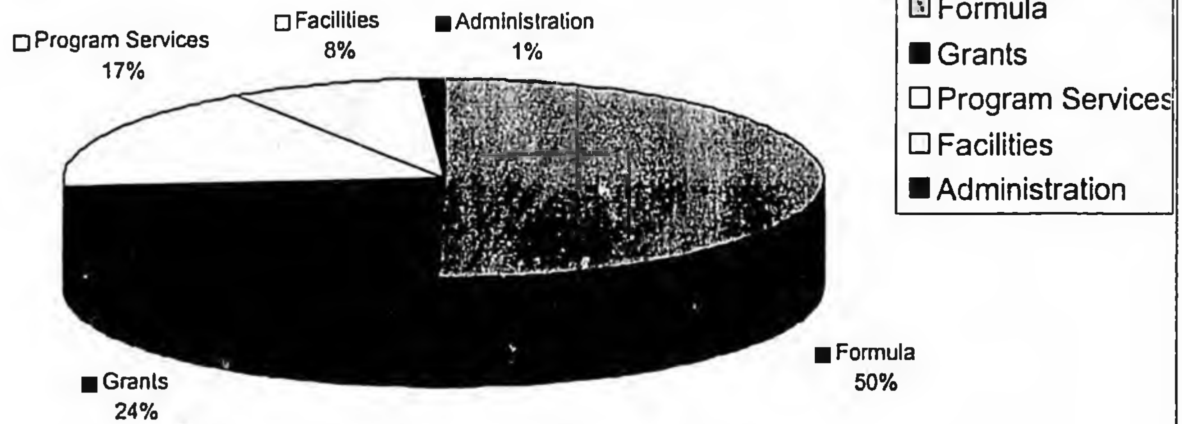
- Through the Office of FAS, participated in the development of community diagnostic teams, provided community grants for programs to prevent FAS and support people with FAS and their families, improved data collection, provided information and technical support.

- Together with state and local partners, supported legislation to establish the Tobacco Use Education and Cessation Fund under AS 37.05.580, which provides for 20% of the Master Settlement to be set aside for tobacco education.

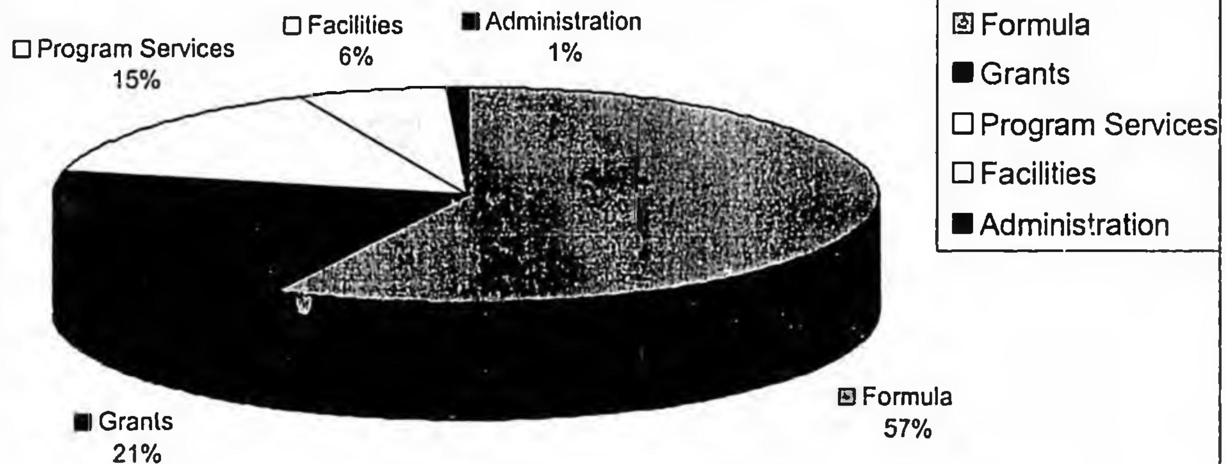
- Established Juvenile Alcohol Safety Action Programs around the state and increased outpatient alcoholism treatment capacity in some locations in Alaska.

Expenditure Category Comparisons of General Fund Authorization

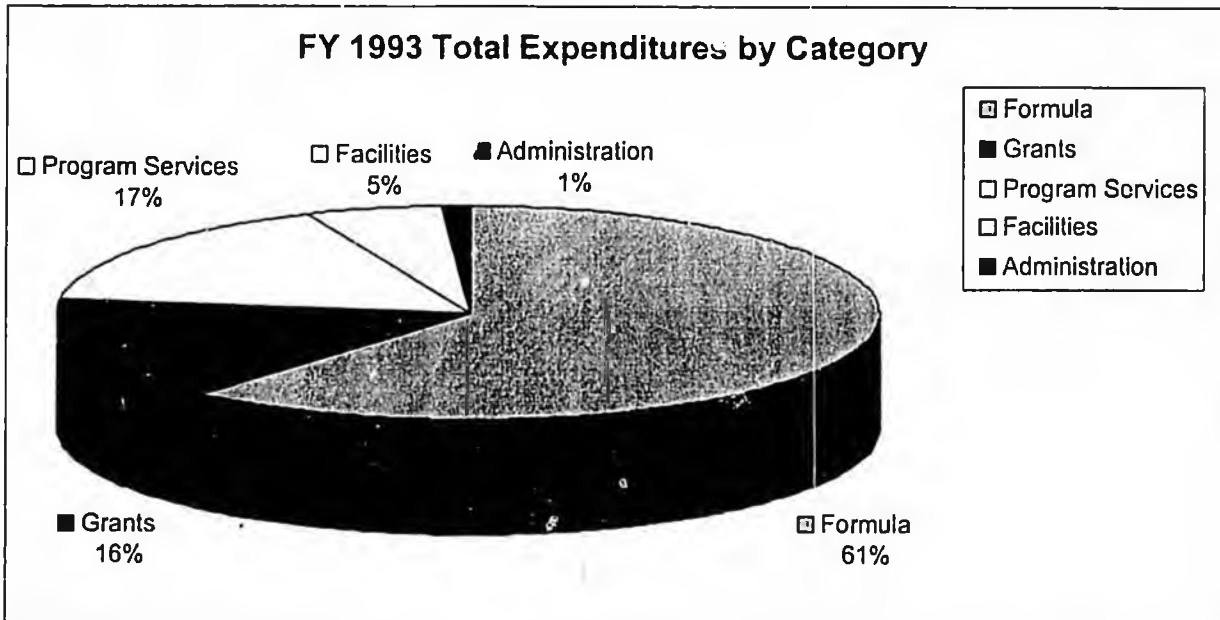
FY 1993 General Fund Expenditures by Category

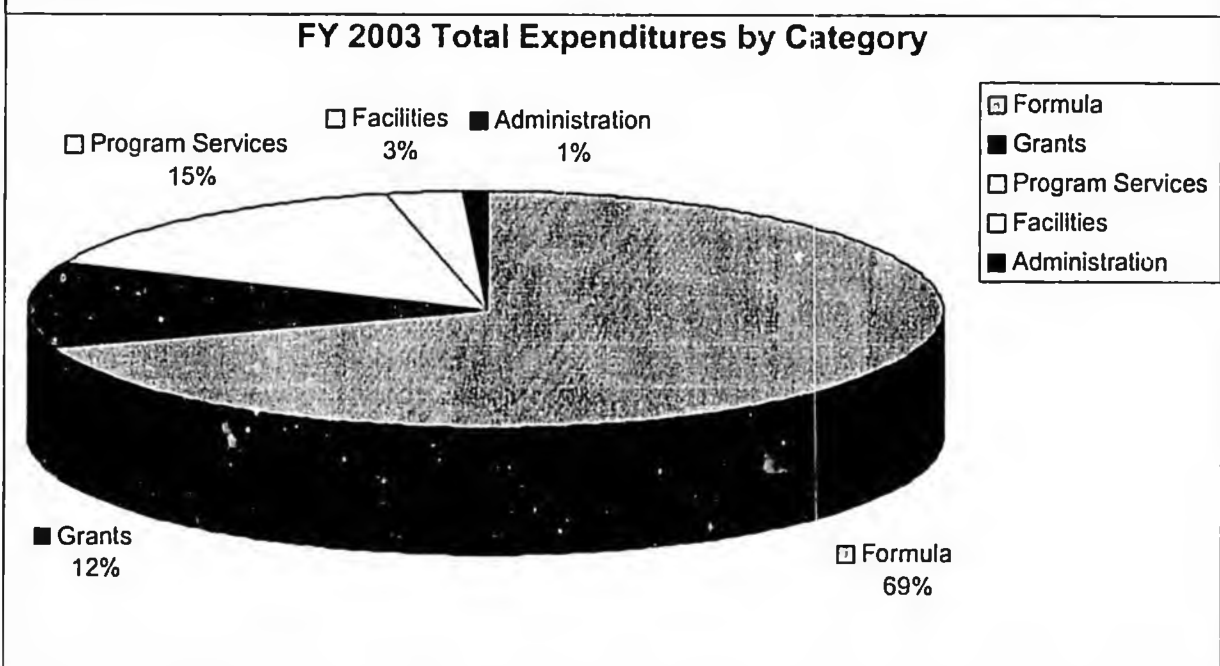


FY 2003 General Fund Expenditures by Category



Expenditure Category Comparisons of Total Funds Authorization





Definition of Categories used in Expenditure Comparisons

Formula Programs include all of the formula programs: Alaska Temporary Assistance Program (ATAP), Adult Public Assistance, General Relief Assistance, OAA-ALB Hold Harmless, Tribal Assistance Programs, Medicaid Services, Catastrophic and Chronic Illness Assistance, Child Care Benefits, Foster Care, Court Orders and Reunification Efforts, and Subsidized Adoption and Guardianship.

Program Services include both administration and delivery of direct services, such as public health nursing and social services, and the administration of entitlements and grants.

Grants include the components with major grants to other organizations or major contracts for service delivery and the Energy Assistance Program.

Facilities include youth correctional facilities and the Alaska Psychiatric Institution.

Administration includes the Commissioner's Office, the other components of the Division of Administrative Services, and the three Mental Health Trust Boards

Missions and Measures

FY 2001

January 22, 2002

Introduction To Performance Measures

DHSS Mission

To promote and protect the health and well being of Alaskans.

The Department of Health and Social Services (DHSS) believes that tracking performance with carefully considered indicators is a critical part of effective management. Over the last several years DHSS has established many performance measures throughout the department, which were used for management purposes. Additionally, over the last few years the legislature has added many more performance measures. During the 2001 Legislative Session, Missions and Measures were adopted in House Bill 250 (Ch. 90, SLA 2001). The next section provides information on the 48 measures added by the Legislature last year.

Division of Public Assistance

Mission

The mission of the Division of Public Assistance is to promote self-sufficiency and provide basic living expenses to Alaskans in need.

Division of Public Assistance

Measure

The percentage of the Alaska Temporary Assistance Program (ATAP) (AS 47.27) families meeting federal work participation rates.

Sec 77(b)(1) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

In September 2001, 43% of all Temporary Assistance families were in countable work activities and had sufficient hours to meet the federal participation rate requirements. In December 2001, 53% of Temporary Assistance families were in countable work activities but not all had enough hours of participation to count in the federal participation rate.

According to the U.S. Department of Health and Human Services Third Annual Report to Congress on the TANF program, Alaska ranks 8th nationwide for adults in employment and 7th in the average number of hours for adults in employment. No state ranked higher in both measures of success.

Benchmark Comparison

Federal law requires that states meet work participation requirements:

	Federal Rate All Families	Caseload Reduction Credit	Federal Adjusted Target Rate	Alaska Rate Achieved
FFY 1998	30%	3%	27%	42%
FFY 1999	35%	18%	17%	46%
FFY 2000	40%	29%	11%	39%
FFY 2001	45%	37%	8%	42%
FFY 2002	50%	40%	10%	

FFY 02 Caseload reduction credit and adjustment target rate are estimated.

Every state's federal work participation rate is adjusted by a caseload reduction credit that reflects the state's success in moving families off of assistance and into employment. In FFY 2001, Alaska's caseload reduction credit was 37%. Based on the caseload reduction credit, Alaska's work participation target was 8%. Thus Alaska more than met the adjusted federal participation requirement.

Background and Strategies

Temporary Assistance is a work-focused program designed to help Alaskans plan for self-sufficiency and to make a successful transition from welfare to work. Federal law requires the state to meet work participation requirements. Failure to meet federal participation rates results in fiscal penalties.

As Alaska's TA caseload declines, a growing portion of the families require more intensive services just to meet minimal participation requirements. Enhancement of TA Work Services will serve to identify and address client challenges to participation.

Division of Public Assistance

Measure

Rate of job retention among adults receiving Temporary Assistance by region.

Sec 77(b)(2) Ch 90 SLA 2001(HB 250)

Alaska's Target And Progress

The rate of job retention for Temporary Assistance recipients statewide was 80% in FFY00 and FFY01. The method used to measure job retention mirrors that required by the federal government for the TANF High Performance Bonus, using quarterly data from the Alaska Department of Labor.

Rate of Job Retention by region:

Central	80%
Coastal	80%
Southeast	79%
Northern	79%

The DPA goal for job retention by Temporary Assistance recipients in FFY02-03 is 80%.

Job retention is measured for a period of 12 months and the recipient must be working in each quarter during the 12-month period.

Background and Strategies

Job retention enables families to reduce or eliminate dependency on welfare. Case management, supportive services and childcare payments are important services which help to improve job retention.

Most often, those Temporary Assistance adults who have the best ability to retain employment are the most likely to leave the caseload. As the caseload declines, those adults with more significant barriers to employment make up a higher percentage of the caseload. Therefore, with a declining caseload it is increasingly difficult to maintain high job retention percentages.

Division of Public Assistance

Measure

Percentage of ATAP adults who have left assistance because they become employed who are receiving day care assistance.

Sec 77(b)(3) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

In FY2001, 20% of ATAP adult-included families who left assistance with earnings and a child less than 12 years old received PASS II child care.

Background and Strategies

Working families who have left Temporary Assistance (PASS I) are guaranteed one year of transitional child care (PASS II) if they need it. The PASS II program is administered by the Department of Education and Early Development. This measure indicates the use of transitional (PASS II) child care assistance by Temporary Assistance clients who have worked their way off of welfare.

In FY01, an average of 151 notices per month were sent to working families who had recently left Temporary Assistance (the cases were closed), informing them about the availability of PASS II child care assistance.

Division of Public Assistance

Measure

The percentage of adults receiving temporary assistance who have earned income.

Sec 77(b)(4) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

Percentage of Temporary Assistance adults with earned income was 31% in September 2001.

The percentage of families leaving Temporary Assistance who reported earnings when they left was 38% in September 2001.

Goal for FY02-03 is 45% of Temporary Assistance adults with earned income, and 45% of case closures with reported earned income.

Background and Strategies

This is a measure of current Temporary Assistance recipients who have earned income. As the caseload declines, those adults with more significant barriers to employment make up a higher percentage of the caseload. Therefore, with a declining caseload, it becomes more difficult to achieve higher percentages of recipients with earned income. The goal of the division's welfare-to-work effort is to move families off assistance and into a job that pays well enough for the family to be self-sufficient. Case management, supportive services, child care and other services are critical to the success of this effort.

Division of Public Assistance

Measure

The rate of payment accuracy for ATAP payments & Food Stamps.

Sec 77(b)(5) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

Temporary Assistance payment accuracy rate was 96% in FFY01.

In FFY98, FFY99 and FFY00 the Food Stamp accuracy rate was 88%, 84%, and 93% respectively. Food Stamp state-calculated payment accuracy rate was 91% for FFY01 as of 10/22/01. FFY01's federally calculated payment accuracy rate will be available April 2002.

The goal for FY02-03 is 94% accuracy in Food Stamps and 98% accuracy in Temporary Assistance.

Benchmark Comparison

The US Department of Agriculture determines acceptable performance for Food Stamp payment accuracy for all states by using a national average after the end of the federal fiscal year (September). States with accuracy rates worse than the national average can receive fiscal penalties. The national average for FFY01 is anticipated to be approximately 90%. In FFY 01 the state calculated Food Stamp accuracy rate was 91%. USDA publishes the national average in the spring each year.

Background and Strategies

Accurate benefits ensure clients have the amount of benefits to which they are entitled. Fluctuating benefits cause budget issues for clients and impact their ability to gain self-sufficiency. The Quality Assessment Reviews evaluate payment accuracy using statistically valid desk reviews.

The failing accuracy rates in FY98 and FY99 were due in large part to the dramatic changes caused by the implementation of welfare reform. Through a settlement with USDA, the Division reinvested a portion of the penalty in a program to improve the rate which resulted in remarkable success during FFY00.

Division of Medical Assistance

Mission

The mission of the Division of Medical Assistance is to maintain access to health care and to provide health coverage for Alaskans in need.

Division of Medical Assistance

Measure

The average time the division takes from receiving a claim to paying it.

Sec 78(b)(1) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

During the last half of FY0' took an average of 11.08 days to pay claims.

Benchmark Comparison

Federal regulation requires that 90% of all clean claims received must be paid within 30 days, and 99% of all clean claims received must be paid within 90 days (42 CFR 447.45 Time of Claims Payment).

Background and Strategies

The assumption is that the timely payment of medical claims gives providers incentive to participate in the Medicaid Program. Therefore, the legislature and the division are interested in a measure of how timely the division responds to or pays claims.

Division of Medical Assistance

Measure

The percentage of claims with no errors categorized by the type of provider.

Sec 78(b)(2) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

Provider Type	Percentage of "Clean Claims"
Pharmacies	80.23%
Dentists	72.96%
Nursing Facilities	69.75%
Physicians	69.01%
Hospitals	57.45%
All Providers	**72.64%**

The percentage of error-free claims reported for FY00 was 73.54%. Only two provider categories reported decreased percentages: physicians and dentists -- both had a less than 1% change from last year.

Benchmark Comparison

The division has requested comparable information from other states, but has not yet received responses to those requests.

Background and Strategies

This is a measure of the providers ability to file error-free claims which reduces the time and effort required to process claims. Those provider types experiencing more problems filing error-free claims are targeted for additional training. We assume that providers who do not experience problems in getting claims paid are much more likely to continue participating in the Medicaid Program.

Division of Medical Assistance

Measures

The percentage of total funds that are used to pay claims compared to the percent used for administration of the division.

Sec 78(b)(3) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

	Current Year (FY01)	Previous Year (FY00)
Claims Payments	96.7%	96.3%
Division Administrative Costs	3.3%	3.7%

Benchmark Comparison

The HCFA publication "Medicaid Statistics Program and Financial Statistics Fiscal Year 1998", the most recent statistical information available, reports a 4.13% administrative cost versus a 95.87% for program payments. The source documented is the HCFA 64.

Background and Strategies

This is a fiscal measure of the State's administrative overhead necessary to support the medical assistance programs.

Division of Medical Assistance

Measure

The percentage of the providers who are participating in the medical assistance program by region.

Sec 78(b)(4) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

Provider Type	Providers Licensed by State of Alaska		Providers Paid at Least Once Medicaid Claim		Percent of Participating Providers	
	FY00	FY01	FY00	FY01	FY00	FY01
Physicians**	1,287	1,282	662	650	51%	51%
Dentists	412	431	221	216	53%	50%
Pharmacies	97	115	74	81	76%	70%
Hospitals	16	16	16	16	100%	100%
Nursing Facilities	15	15	15	15	100%	100%

** The total number of unduplicated physicians who had at least one paid claim during FY01 was 815. The discrepancy between the total of 815 and the 662 licensed physicians charted above can, at least in part, be attributed to the exclusion of Indian Health Services (IHS) physicians in the Occupational Licensing database. IHS physicians are not required to be licensed by the State of Alaska.

We feel we are making progress in our goal of increasing provider participation, but are still unable to measure any success effectively.

Background and Strategies

This is a measure of Alaska's medical assistance clients' access to medical services through the same network of medical providers available to the balance of the State's population.

The Division continues to work towards complying with this Performance Measure requirement. However, we have had some difficulties.

To provide geographical information on providers, each provider must be matched by city. Therefore, the definition of each region needs to be defined clearly and each city pointed to a region to establish a total.

In addition, provider enrollment data in MMIS has not been purged since 1979. The number of enrolled providers exceeds 8,000. A data purge would be a lengthy and expensive undertaking, and for that reason, has not been done. This means MMIS fiscal year claim payment data must be

compared to Occupational Licensing data - two separate databases without comparable data parameters. For instance, a provider may have several Medicaid provider ID's, one for each rendering address, each in a different region, but only one address within the Occupational Licensing file. A further complication arises because physicians practicing in the Medicaid program through the Indian Health Services need not be licensed with the State of Alaska and will not be included in the Occupational Licensing database.

It is also extremely difficult to identify unduplicated providers within a region and match them with comparable claims paid data. For example, a physician licensed to practice in the State of Alaska may do so through several different facilities in several different regions.

The division will continue to define and refine its methodology to respond to this measure in the most effective way possible.

Division of Family and Youth Services

Mission

The mission of the Division of Family and Youth Services is to protect children who are abused and neglected or at risk of abuse and neglect.

Division of Family and Youth Services

Measure

The number of children substantiated as abused or neglected and the number of children unconfirmed as abused or neglected by region.

Sec 79(b)(1) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

1) The number of children substantiated as abused or neglected:

FY1997	3,267 of 7,563 (43.2%) children substantiated as abused or neglected
FY1998	3,690 of 8,128 (45.4%) children substantiated as abused or neglected
FY1999	3,568 of 7,592 (47.0%) children substantiated as abused or neglected
FY2000	3,266 of 6,598 (49.5%) children substantiated as abused or neglected
FY2001	4,122 of 8,865 (46.5%) children substantiated as abused or neglected

2) The number of children substantiated as abused or neglected by region:

FY2001	
Anchorage Region	1,338 of 3,249 children
Southcentral Region	1,232 of 2,335 children
Northern Region	1,246 of 2,361 children
Southeast Region	306 of 920 children
FY2001 Total	4,122 of 8,865 children

3) The number of children unconfirmed as abused or neglected by region:

FY2001	
Anchorage Region	1,700 of 3,249 children
Southcentral Region	908 of 2,335 children
Northern Region	879 of 2,361 children
Southeast Region	448 of 920 children
FY2001 Total	3,935 of 8,865 children

Background and Strategies

Workers conclude every assigned investigation with a determination that the report of harm was substantiated, unconfirmed, or invalid. A substantiated report of harm is one where the available facts indicate a child has suffered harm as a result of abuse or neglect as defined by AS 47.10.011. An unconfirmed report of harm is one where, based on the available facts, the worker is unable to determine if a child has suffered harm as a result of abuse or neglect. An invalid report is one where there are no facts to support the allegation that a child has suffered abuse or neglect.

This measure is also required for the Federal Review. The Federal Review is conducted by the U.S. Department of Health and Human Services.

The Federal Review measure most related to this State measure is *Disposition of Child Abuse and Neglect Reports*. This measure is based on the disposition or finding of any child who was the subject of an investigation in a particular report, and includes the number and percentages of reports and of children. For this measure, the division reports the:

Number of children who had a substantiated or unconfirmed report.

The division recommends that the same measure for the Federal Review be used for this State measure in the future.

Measure

The incidence of child abuse or neglect in foster care.

Sec 79(b)(2) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

The Division's target is zero inci iences of child abuse or neglect in foster care.

Number Of Children With Substantiated Incidents Of Maltreatment In Licensed Foster Care By Region and By Type of Maltreatment FY 01 (Legislative Outcome Data)

Region	**Number of Children**	**Physical Abuse**	**Sexual Abuse**	**Neglect**	**Emotional Injury**	**Abandon-ment**
NRO	15	3	0	10	0	
SC	9	4	2	1	2	
ARO	8	5	0	2	1	
SE	1				1	
Total All Regions	33	14	2	13	4	0

Background and Strategies

Background:
These 33 children were represented in 22 foster homes, less than 2 percent of the total licensed foster homes during this period of time.

Of the 22 foster homes, 11 of them closed as a result of the substantiated finding, 7 of them remained licensed with the child placed in the home, 2 of them were closed due to an adoption by a foster parent who was also a relative to the child, and 2 of them remain licensed without the child placed in the home. All of the homes that did not close as a result of the substantiated finding were either counseled, consulted, or had a plan of correction, and they succeeded in their plan of correction.

In response to a substantiated finding in a foster home, the division usually offers advise and consultation to correct the foster parent's behavior, a formal plan of correction which might include training for the foster parent, a license modification such as reducing the number or age range of children cared for, or formal revocation of the foster license. If

the child has been previously removed, a decision will be made if the removal is to become permanent. The decision on whether to remove a child after a substantiated finding is impacted by many variables. These include consideration of the nature and seriousness of the incident as well as the foster parents' response. The duration and level of the foster parent and foster child relationship is considered. The wishes of the foster child, if age appropriate, are considered. The safety of the child is paramount in any decision that is made.

Strategies:
The Federal Review also includes this same measure. It is defined as follows: Of all children who were served in foster care during the reporting period, what percentage was the subject of substantiated or indicated (unconfirmed in Alaska) maltreatment by a foster parent or facility staff? Both the percentage and total number of children are provided. This group also includes relatives who are caring for children in state custody.

•*Continue the APSIN Flag program.* This program is a collaborative, on-going effort between the Department of Public Safety and the Division of Family and Youth Services. All licensed caregivers are entered into APSIN and if there is ever a police response to the home, the division is immediately notified.

•*Provide Foster Parents and Relative CareGivers the support and information they may need.* Essential to meeting this strategy is a effective training program for caregivers. The division offers training to all licensed caregivers and tracks the amount of training each foster parent receives annually.

Division of Family and Youth Services

Measure

The number of children in state custody longer than 18 months and 36 months.

Sec 79(b)(3) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

The target for this measure is no child waits longer than 2 years or more to leave state custody

FY2001 1,049 of 1,937 (54 percent) children were in state custody for 18 months or longer.

FY2001 501 of 1,937 (26 percent) children were in state custody for 36 months or longer.

Background and Strategies

The Federal Review has two related measures that are defined as follows:

Median length of stay in foster care; and

Number of children in care 17 of the most recent 22 months.

The division recommends that the same measure for the Federal Review be used for this State measure in the future. The division is currently working on developing the new data and it will be available by the end of January 2002.

Division of Family and Youth Services

Measure

The length of time in state custody before achieving adoption.

Sec 79(b)(4) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

The target for this measure is 6 months from termination of parental rights.

FY1997	17.4 months
FY1998	19.8 months
FY1999	14.5 months
FY2000	15.1 months
FY2001	12.0 months

Background and Strategies

This measures the length of time in months to achieve adoption from the point in time when both parents' rights have been terminated or when they relinquish their rights to the point in time when the adoption is final.

Alaska's length of time has been declining since 1998.

The division has undertaken a number of programs that have been and continue to be fundamental in achieving a shortened time frame before a child achieves adoption, they are:

* *Continue Adoption Placement Program (Balloon Project) and Project Succeed*
* *Promote the Alaska Adoption Exchange*
* *Provide training to adoptive parents with special needs children*
* *Implementation of SNAP, the Simple New Adoption Process*
* *Continue the Home study Project*

Division of Family and Youth Services

Measure

The average length of time in state custody before achieving reunification.

Sec 79(b)(5) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

The target for this measure is to maintain FY2001 timeframe of 9.6 months.

FY1999	9.3 months
FY2000	9.9 months
FY2001	9.6 months

Benchmark Comparison

The Federal Review has a related measure that is a comparison across States. The measure is defined as follows:

> Of all children who were reunified with their parents or caretakers at the time of discharge from foster care, what percentage was reunified in less than 12 months from the time of the latest removal from home.

The division recommends that the same measure for the Federal Review be used for this State measure in the future. It is crucial that proposed actions to establish family visitation centers to maintain this timeframe or even to improve the current time frame.

Background and Strategies

Many factors contribute to when reunification can or should occur. Workers consider progress and change on the part of the family members in remedying the situation that caused the child to be removed when considering reunification. A premature reunification can lead a child back into custody and placement outside of his or her home, so it is important that the timing is right for the family. Likewise, a delay in reunification can lead to frustration and a loss of any progress made by the parents or family members.

Division of Family and Youth Services

Measure

The number of child-days that foster homes were found to be beyond license capacity by location.

Sec 79(b)(7) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

The target for this measure is 0 child-days.

In FY2001 only one foster home was beyond license capacity:

Anchorage: 1 foster home beyond capacity for 9 days

Background and Strategies

Licensing requirements specify no more than two children in each foster home is allowed. However, there are instances where variance or exemptions are made to this requirement. It mostly occurs when groups of siblings are placed together. Any licensed foster home with more than two children receives special variance or exemption.

There is no related measurement for the Federal Review, although, the Review will look for instances where siblings are not placed together. There should be well-documented reasons for not placing siblings together.

Division of Family and Youth Services

Measure

The number of closed cases in which there is a reoccurrence of maltreatment.

Sec 79(b)(6) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

The target for this measure is 13 percent by FY2003. The national standard used for this measure in the Federal Review is 6 percent.

FY1999 962 of 4,147 (23.2%) closed cases had a reoccurrence of maltreatment
FY2000 1,212 of 4,592 (26.4%) closed cases had a reoccurrence of maltreatment
FY2001 999 of 4,233 (23.6%) closed cases had a reoccurrence of maltreatment

Background and Strategies

This measure is the same as one used in the Federal Review. Recurrence of Maltreatment is defined as follows:

> Of all children who were victims of substantiated or indicated (unconfirmed in Alaska) child abuse and/or neglect during the first 6 months of the reporting period, what percentage had another substantiated or indicated report within a 6-month period?

The Federal Review will provide more of an analysis of why so many children are being re-reported. Once the analysis is completed the division will develop action plan to achieve the national standard of 6%.

Division of Family and Youth Services

Measure

The percentage of legitimate reports of harm that are investigated.

Sec 79(b)(8) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

The target for this measure is 100 percent of all legitimate reports of harm will be investigated.

FY1997	73.6 percent
FY1998	77.3 percent
FY1999	78.1 percent
FY2000	88.8 percent
FY2001	90.7 percent

Background and Strategies

Reports of harm are prioritized according to the immediate or potential risk of harm to the child. A priority 1 rating is the most serious and must be responded to within 24 hours from the time the Division receives the report. Priority 2 reports of harm must be responded to within 72 hours of receipt of the report. Priority 3 reports are considered low risk and must be responded to within one week of receiving the report.

Early intervention for family support enables the Division to focus more social workers on investigating higher priority reports of harm. This allows for early intervention that minimizes the risk to children and often negates the need for out-of-home placements or further intervention.

Not enough staff seriously effects the Division's ability to respond to all legitimate reports of harm. More staff is needed. More efficient work processes are needed. The division is working on a new MIS system.

Division of Family and Youth Services

Measure

The turnover rate of the Division of Family and Youth Services staff by region.

Sec 79(b)(9) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

The target for this measure is 10 percent turnover rate in all regions.

Statewide	FY1998	32.60 percent
	FY1999	32.54 percent
	FY2000	21.53 percent
	FY2001	24.84 percent

FY2001 by Region

Region	Percent
Anchorage	29.17 percent
Southcentral	12.73 percent
Northern	24.75 percent
Southeast	28.26 percent

Background and Strategies

There are many reasons why staff leave their jobs. Chief among those reasons include caseload size, relationship with supervisor, and low salary. Caseload size in Anchorage office drove the increase between 2000 and 2001. Caseloads were more than double the national standard. The difficulty in recruitment delayed some hires which caused caseloads to remain high through staff vacancy periods.

In July 2001, the minimum qualifications for social workers changed, now requiring high qualifications to do the same job. The job market is very competitive, making salaries lower than usual for the type of work and qualifications needed.

P17

Division of Family and Youth Services

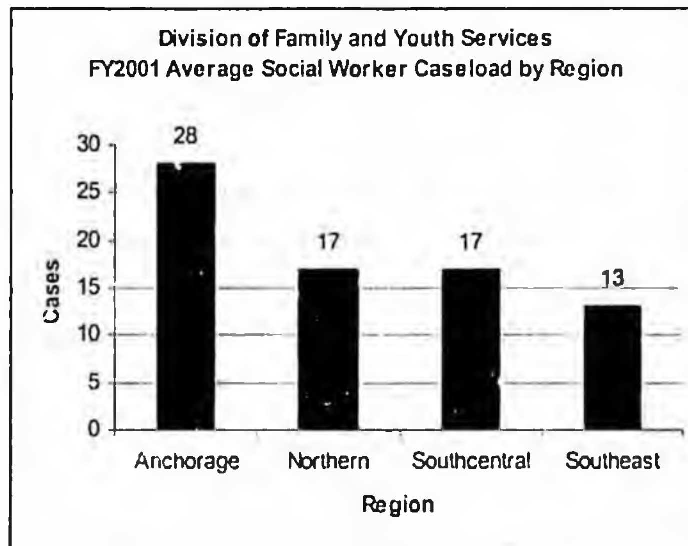
Measure

The average social worker caseload by region.

Sec 79(b)(10) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

The Division's target is 15 families per worker.



Background and Strategies

National caseload standards established by the Child Welfare League were used for comparison. The Child Welfare League's national caseload standard for the Anchorage region is 15. The national standard for the Southcentral Region is 13. The national standard for the Northern Region is 14 and for the Southeast Region 14. The national statewide total is 14 cases per worker.

The FY 2001 Southeast Region workload was 13 cases per employee. This represents the average for the region. Although the workload of the field offices such as Juneau, and Ketchikan exceeds the national workload standard, single employee offices has less than the national average resulting in a caseload less than the national average. These single employees offices are crucial to provide services to these communities and often their work in the community reduces the child abuse and neglect.

Division of Juvenile Justice

Mission

The mission of the Division of Juvenile Justice is to protect and restore communities and victims while holding juvenile offenders accountable for correcting their behavior.

Division of Juvenile Justice

Measure

The percentage of Juvenile Offenders that Re-Offend.

Sec 80(b)(1) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

The percentage of Juvenile Offenders during FY2001 that Re-Offended was 46%. This is down from the FY2000 rate of 65%.

This measure consists of the re-offense rates of youth who have been released from a Juvenile Justice long-term treatment facility. A recidivist is a youth who, within 24 months of release from a long-term treatment facility, has obtained either: a new juvenile institutional order or, a new juvenile adjudication or an adult conviction.

Background and Strategies

It is important to understand that this recidivism performance measure focuses on a small, albeit significant, portion of the Division of Juvenile Justice's clientele. The Division works effectively with a much larger client base. For example, in FY 2001, 4,864 juveniles (unduplicated count) were referred to the Division. Of this number, 2693 (55%) responded quickly to intervention and did not require ongoing formal probation services, nor did they penetrate further into the system. Of the 2,171 who required probation supervision, only 220 (10%) received B1 court orders for placement in the Division's secure long-term treatment facilities. While the FY 2001 recidivism data reported in this measure does not track the results of these specific 220 juveniles (because they have not been released in this fiscal year), these numbers are illustrative in understanding that the bulk of the work done by the Division is with juveniles who are **not** placed in secure facilities.

The Division of Juvenile Justice engaged in a series of involved internal discussions on re-offense measures before establishing the criteria used to produce this performance benchmark. Setting the benchmark to trigger the re-offense count at the point of conviction or subsequent adjudication eliminated those contacts with law enforcement which were dismissed or never pursued by the prosecutor. The established benchmark also excluded minor violations such as fish and game and traffic offenses which are not necessarily always indicative of criminal behavior.

The two-year time frame set a stringent standard for the Division, but with this time frame as the benchmark, the Division felt the measure was a reliable indicator as to the effectiveness of the Division's efforts to positively impact the non-re-offense rates by those who went through our programs. There is no single, nationally accepted re-offense standard or definition. Jurisdictions around the country vary widely in the way they measure re-offense data. Alaska's definition and re-offense outcome measure was structured in a fashion which the Division believes strikes a balance between what we

believe can be reasonably measured while assessing criteria which give the Division, the Legislature and the public a meaningful measure to assess the effectiveness of the Division's programs and services.

Division of Juvenile Justice

Measure

The percent of ordered restitution and community work service that is paid or performed by the Juvenile Offender.

Sec 80(b)(2) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

The FY2001 statewide Division of Juvenile Justice amount of Restitution ordered was $349,660 and the amount paid by juvenile offenders was $306,674, or 87.7% of what was ordered.

The FY2001 statewide Division of Juvenile Justice amount of Community Work Service hours ordered was 28,926 and the amount performed by juvenile offenders was 25,616, or 88.6% of what was ordered.

For the restitution measure the benchmark is 79%.
For the community work service measure the benchmark is 83%.

Background and Strategies

This performance measure consists of two components that provide a gauge of the Division of Juvenile Justice's effectiveness with assisting delinquent youth in being accountable to his or her victim and community for their delinquent behavior, as well as the youth providing restoration to his or her victim and community for their delinquent behavior.

This measure consists of:

-The percentage of restitution paid for cases where there was a restitution order (either by the court or the Probation Officer). This measure shall be determined at case closure. Case closures occur when a court order has been given to close a case, a court order has expired, or informal adjustment has been made by the Probation Officer.

-The percentage of community work service performed for cases where there was a community work service order (either by the court or the Probation Officer). This measure shall be determined at case closure. Case closures occur when a court order has been given to close a case, a court order has expired, or informal adjustment has been made by the Probation Officer.

Division of Juvenile Justice

Measure

The number of escapes from Juvenile Institutions.

Sec 80(b)(3) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

The following table reflects the institution escapes in FY2000 & FY2001

Division of Juvenile Justice Institutional Escapes		
Facility	**FY2000**	**FY2001**
Bethel Youth Facility	1	0
Fairbanks Youth Facility	2	*6
Johnson Youth Center	0	0
Mat-Su Youth Facility	**NA	2
McLaughlin Youth Facility	4	0
Nome Youth Facility	0	0
Total	7	8

*Four Fairbanks residents escaped during an outing to an Alcoholics Anonymous Meeting.

**The Mat-Su Facility opened in October 2000.

The benchmark for this measure is the average number of escapes that occurred during FY1995 through FY1997: 9.

Background and Strategies

This performance measure provides a gauge of the Division of Juvenile Justice's effectiveness in providing safety to communities.

This measure consists of the number of youth in Juvenile Justice custody who escape from a Juvenile Justice institution. An escape is defined as an unauthorized departure of a youth from a secure juvenile facility or a secure unit in a facility, or from a direct staff-supervised activity such as court escort, a transfer to another facility, or supervised community activity.

Measure

Rate of recidivism of youth in the juvenile justice system by region and by race.

Sec 80(b)(4) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

The following table reflects the rate of recidivism of youth in the juvenile justice system by region and by race.

Division of Juvenile Justice Institutional Recidivism By Region FY2001				
Facility	Baseline*	# Youth Released	FY2001 Reoffended	% Reoffended
Bethel Youth Facility	70%	8	6	75%
Fairbanks Youth Facility	65%	19	6	32%
Johnson Youth Center**	NA	NA	NA	NA
McLaughlin Youth Facility	47%	106	49	46%
Total	65%	133	61	46%

*The baseline for youth facilities was established by averaging the rates of recidivism for each facility. For McLaughlin Youth Center there is more than ten years of data available. For all of the other facilities there is less data and comparisons should be viewed with caution. Additionally, there are wide variations from year-to-year with McLaughlin data and the overall trend is more significant than any of one year of data.

** The treatment unit at Johnson Youth Center opened April 1999 and did not release youth until FY2000.

The target for the facilities is to maintain or decrease recidivism from the established base line which was established at a re-offense rate of 65% in FY2000 for all DJJ facilities. FY2001 data shows a decrease in the overall statewide rate to 46%.

Division of Juvenile Justice ***Institutional Recidivism By Race***			
Race	**Youth Released**	**Youth Who Re-Offended**	**Recidivism Rate**
Caucasian	78	31	40%
African American	13	6	46%
Native American	32	18	56%
Asian/Pacific Islander	5	2	40%
Unknown	5	4	80%
Total	**133**	**61**	**46%**

The recidivism rates should be interpreted with caution as they are based on a small number of occurrences. No statistically significant difference exists in the rate of recidivism by race.

The division recognized that establishing recidivism as a performance measure would prove to be difficult and potentially problematic. While it is intuitive that recidivism should be measured there is no single, nationally accepted re-offense standard or definition. Very few states even attempt to measure recidivism and for those that do the standards vary widely. For example, one common measure used by facilities is to only count those juveniles who return to their facility as a recidivist. Cleary this excludes a whole range of circumstances, i.e. juvenile is too old, moves out-of-state, commits an offense but is not returned to the facility, all of which increase the success rate of the facility. Similarly, Oregon, which is recognized as one of the leading states in the field of juvenile justice, does not track juveniles past the age of juvenile jurisdiction, or eighteen or those who enter the adult system. Alaska's measure, by contrast, tracks juvenile offense history for two years from the time a juvenile is released from a youth facility, irrespective of age, and accesses adult arrest records to determine if there is no new offense activity. By establishing a two-year measure the Division believes that the results are a strong indicator of the programs impact on juvenile offenders.

The Division's re-offense outcomes measure strikes a balance between what we believe can be reasonably measured while assessing criteria to provide a meaningful measure to assess the Division's progress in providing effective programs and services to juveniles.

Background and Strategies

It is important to understand that this recidivism performance measure focuses on a small, albeit significant, portion of the Division of Juvenile Justice's clientele. The Division works effectively with a much larger client base. For example, in FY 2001, 4,864 juveniles (unduplicated count) were referred to the Division. Of this number, 2693 (55%) responded quickly to intervention and did not require ongoing formal probation services, nor did they penetrate further into the system. Of the 2,171 who required probation supervision, only 220 (10%) received B1 court orders for placement in the Division's secure long term treatment facilities. While the FY 2001 recidivism data reported in this measure does not track the results of these specific 220 juveniles (because they have not been released in this fiscal year), these numbers are illustrative in understanding that the bulk of the work done by the Division is with juveniles who are **not** placed in secure facilities.

This measure consists of the re-offense rates of youth who have been released from a Juvenile Justice long-term treatment facility. A recidivist is a youth who, within 24 months of release from a long-term treatment facility, has obtained either: a new juvenile institutional order or, a new juvenile adjudication or an adult conviction.

See performance measure "The percentage of juvenile offenders that re-offend" for more detailed discussion of re-offender data.

Division of Juvenile Justice

Measure

The number of juvenile offenders who are maltreated while in state custody.

Sec 80(b)(5) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

The following table reflects the number of juvenile offenders who were maltreated while in state custody.

Division of Juvenile Justice Custodial Maltreatment	
Facility or Probation Region	*1st Quarter FY2002
Anchorage Region	4
Southcentral Region	0
Southeast Region	0
Northern Region	1
Total	5

*Covering the period of July 1, 2001 through September 30, 2001.

During an average fiscal year quarter, the Division of Juvenile Justice has approximately 750 youth in custody at some point during the quarter.

Background and Strategies

This measure consists of the number of Division of Juvenile Justice's youth who are the subject of a report to either the Division of Family Youth Services or a law enforcement agency that alleges maltreatment (i.e., neglect, physical abuse, sexual abuse, abandonment, or mental injury), where the alleged maltreatment occurred when the youth was in the legal custody of the Division of Juvenile Justice, regardless of where the child was placed. Placement could be in a youth facility, foster care home, or in a resident treatment home.

Division of Public Health

Mission

The Mission of the Division of Public Health is
to preserve and promote the state's public health.

Measure

The percentage of two-year-old children in the state who are fully immunized

Sec 81(b)(1) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

The target by 2010 is 90% of all 2 yeai olds fully immunized.

The percentage of fully immunized 2-year-olds for calendar year 2000 was 77%.

69% were immunized by the end of 1996.

Background and Strategies

In 1997, the Department launched a major initiative to increase the rate of fully immunized two-year-olds. In three years, we have jumped up 20 positions, going from 48th to 28th in national rankings. Now, over 75% of our two-year-old children have received their recommended vaccines. The Department successfully implemented the new daycare and school immunization requirements in the fall of 2001, vaccinating all school children against hepatitis A and hepatitis B and all daycare attendees against hemophilus influenza type b and chickenpox.

Measure

The percentage of families who are qualified for the services of the infant learning program who are enrolled in the program

Sec 81(b)(2) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

The target for the Early Intervention/Infant Learning Program (EI/ILP) is to eliminate the waitlist during FY2002 with funds provided by the legislature and ensure that 100% of eligible or qualified children and families are enrolled in the program. In FY2001, 1737 children were enrolled in the Infant Learning Program and there were 329 children on the waitlist (point-in-time on 6/30/01) for services for a total of 2066 eligible children. During FY2001, 76% of children qualified for services received EI/ILP services during each quarter of FY2001. On 6/30/01, 329 children remained on the waitlist for EI/ILP services.

This was a new measure for FY2000, therefore historical data have not been reported. During FY2000, 1626 children were enrolled in services and 307 were on the waitlist* (point-in-time on 6/30/00) for a total of 1933 eligible children. The average quarterly percentage of eligible children enrolled in EI/ILP services was approximately 72% during each quarter of FY2000. The percentage of qualified children who were enrolled in EI/ILP during each quarter of FY2001 increased approximately 4% from 72% in FY2000 to 76% for each quarter of FY2001.

Background and Strategies

Since FY1999, the three-year Early Intervention Enhancement and Improvement Opportunity (EIEIO) has enhanced the identification of rural children in need of EI/ILP services, increased services to enrolled children and families, and enhanced the infrastructure of the overall system in order to provide ongoing services to more children and families. A $700.0 GF/MH increment to eliminate the waitlist* became available for FY2002 and has been disbursed to EI/ILP grantees across the state.

*Waitlist = children who have been referred for screening, evaluation and/or enrollment in EI/ILP services and who have not been enrolled within 45 days of their initial referral and are still waiting for these services. Children eligible for Part C should never be waitlisted. Waitlist data are collected and reported point-in-time each quarter and should not be compared to cumulative enrollment during a fiscal year.

Measure

The rate of Tuberculosis cases by race and region

Sec 81(b)(3) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

The 2010 target is 6.8 cases per 100,000 population, which is the current baseline rate for the U.S. (1998).

Region	FY 2000 Rate per 100,000 Population	Cases
Anchorage/Mat-Su	11.7	37
Gulf Coast	6.8	5
Interior	7.1	7
Northern	76.3	18
Southeast	4.1	3
Southwest	98.8	38
TOTAL	**17.4**	**108**

The number of tuberculosis cases by race: Race for 108 cases – 11 white; 9 black; 71 Alaska Native; 17 Asian or Pacific Islander.

The average TB rate over the decade (1991-2000) was 12.5/100,000 population.

Background and Strategies

Tuberculosis has been a long-standing problem in Alaska and was the cause of death for 46% of all Alaskans who died in 1946. Major efforts, which included 10% of the entire state budget in 1946, led to one of the state's most visible public health successes-major reductions in TB across the state. Now this disease is reemerging and with it the threat of treatment resistant strains of the disease. Inadequate resources to monitor and educate those most at risk have resulted in continual outbreaks. Significant new resources are needed to do the case finding, diagnostic tests and treatment follow-up required to keep the disease in check.

Division of Public Health

Measure

The rate of child hospitalizations and fatalities related to injury

Sec 81(4) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

The 2010 target is 9.9 injury fatalities per 100,000 0-19 year olds.

Rate of Injury of Children 0-19 *(rate per 100,000)*	1996	1999
Injury Fatalities	43	31.7
Non Fatal Injury Hospitalizations	499.4	534.8*

*82% unintentional injuries; 18% related to suicide attempts, assault or other intentional injury.

No comparable US rate is available. In 1999 the discharge rate for children under 15 years old was 379/100,000 for injury and poisoning hospitalizations.

Background and Strategies

The Alaska Trauma Registry and Vital Statistics systems provide information on deaths and hospitalizations related to injury to children. The data provide very useful information for evaluating and refining child and adolescent injury prevention strategies. They show that one third of injury deaths of children are due to "intentional" injuries while 16.5% of non-fatal injury hospitalizations are due to intentional injuries.

Efforts geared towards putting smoke alarms in every home, having children wear bike helmets, ensuring proper and continual use of car seats and other educational campaigns have likely reduced child fatalities due to injury. Reducing firearm and ATV injuries are potentially promising areas for saving lives and health care resources. Hospital costs alone for children's injuries in Alaska are estimated to exceed $10 million per year.

Measure

The rate of hepatitis C cases

Sec 81(b)(5) Ch 90 SLA 2001 (HB250)

Alaska's Target and Progress

No 2010 targets have been established, since reporting has not been in place long enough to determine a benchmark.

The number of hepatitis C cases in 2000 is 870 case reports from Labs. These tests reflect both newly infected and those who have been infected for some time but are being tested for the first time - so the numbers cannot be used to determine current infection rates.

Reports of positive hepatitis C laboratory tests:

Number of Positive Hepatitis C Laboratory Tests Reported

Year	Number of Positive Tests	Ak Population	# positive tests/100,000 population
1996*	245	605,212	40.5
1997	570	609,655	93.5
1998	1003	617,082	162.5
1999	1196	622,000	192.3
2000	870	626,932	138.8

* *1996 was 1st reporting year*

Division of Public Health

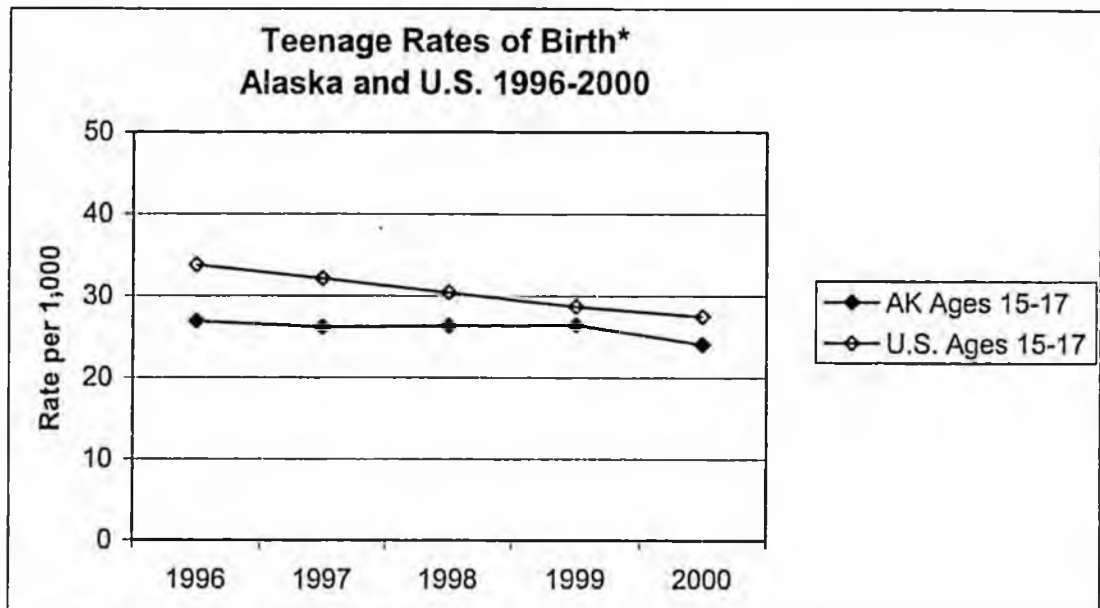
Measure

The rate of unmarried and married teen births.

Sec 81(b)(6) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

The 2010 target for births to young teens is 18 per 1,000 girls ages 15-17. (Current Alaska rate is 24.1; U.S. rate is 27.5 in 2000)



Source: Alaska Bureau of Vital Statistics

•**Teen Birth Rates: Alaska and U.S., 1996-2000** From 1996 to 2000, the birth rate for Alaska females ages 15-17 fell by over 10 percent (from 26.9 in 1996 to 24.1 in 2000). Over the same period, the U.S. birth rate for females ages 15-17 fell by 18.6% (from 33.8 to 27.5).

•Although Alaska's birth rate for 15-17 year-old teens did not fall as steeply as the U.S. rate, it remained below the U.S. rate throughout the five-year period (1996-2000).

Background and Strategies

The teen birth rate in 1998 reached the Healthy Alaskans 2000 goal of fewer than 50 per 1,000 girls aged 15-19, down from 66.2 in 1990. Activities to educate on the risks associated with unmarried and teen child bearing, together with increased access to reliable contraception, may have influenced these numbers.

Division of Public Health

Measure

The rate of new cases of sexually transmitted diseases

Sec 81(b)(7) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

Implementation of a non-invasive mode of testing for Gonorrhea and Chlamydia has the potential to increase case finding, partner notification, and more timely follow-up.

1. Chlamydia: Reduce the chlamydia rate to 114 cases per 100,000 by FY 2010.

Year	Rate per 100,000
2000	413
1999	304

Based on current data, the 2001 rate will be higher than the 2000 rate.

2. Gonorrhea: Reduce the gonorrhea rate to 9 cases per 100,000 by FY 2010.

Year	Rate per 100,000
2000	58
1999	49

Based on current data, the 2001 rate will be higher than the 2000 rate.

3. HIV: Reduce the mean annual rate of new Alaska AIDS cases to fewer than 1.0 per 100,000 per year for the period from 2005-2010. The mean annual rate of Alaska AIDS cases diagnosed from 1996-2000 was 4.4 cases per 100,000 population.

Benchmark Comparison

The U.S. chlamydia rate in 2000 was 257.5 cases per 100,000 population. Chlamydia rates for 2000 in Washington, Oregon, Montana and Idaho were 227.0, 214.3, 166.4, and 152.4 per 1000,000, respectively.

The U.S. gonorrhea rate in 2000 was 131.6 cases per 100,000 population. Gonorrhea rates for 2000 in Washington, Oregon, Montana and Idaho were 42.0, 31.3, 6.8, and 7.8 per 100,000, respectively.

AIDS case rates for 2000 for the U.S. as a whole, Washington, and Oregon were 14.4, 8.7, and 6.1 cases per 100,000 population, respectively. Five-year mean annual AIDS case rates would be the most comparable measures for the low prevalence states of Idaho and Montana, but are not available.

Background and Strategies

Targeted screening and increased disease investigation activities have actually increased the total numbers of STD cases diagnosed. These activities effectively identify infected individuals with no symptoms and also identify and treat exposed individuals before they develop symptoms or further transmit infection. Case numbers are expected to decline over time as these activities reduce the reservoir of infected individuals in the population.

HIV disease investigation activities work with HIV-infected persons to notify their partners of their exposure to HIV and offer them HIV counseling and testing. A small number of individuals are newly diagnosed each year and assisted t access care. Uninfected individuals who have been exposed to HIV are counseled about preventing future infection

Division of Alcohol and Drug Abuse

Mission

The mission of the Division of Alcoholism and Drug Abuse is to reduce alcoholism and substance abuse.

Division of Alcohol and Drug Abuse

Measure

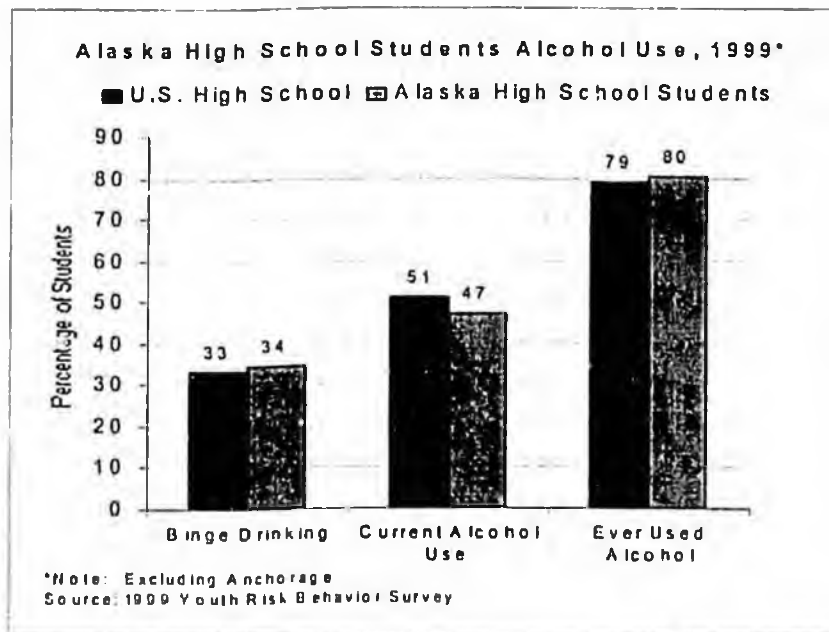
The rate of binge or chronic drinking by age group.

Sec 82(b)(1) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

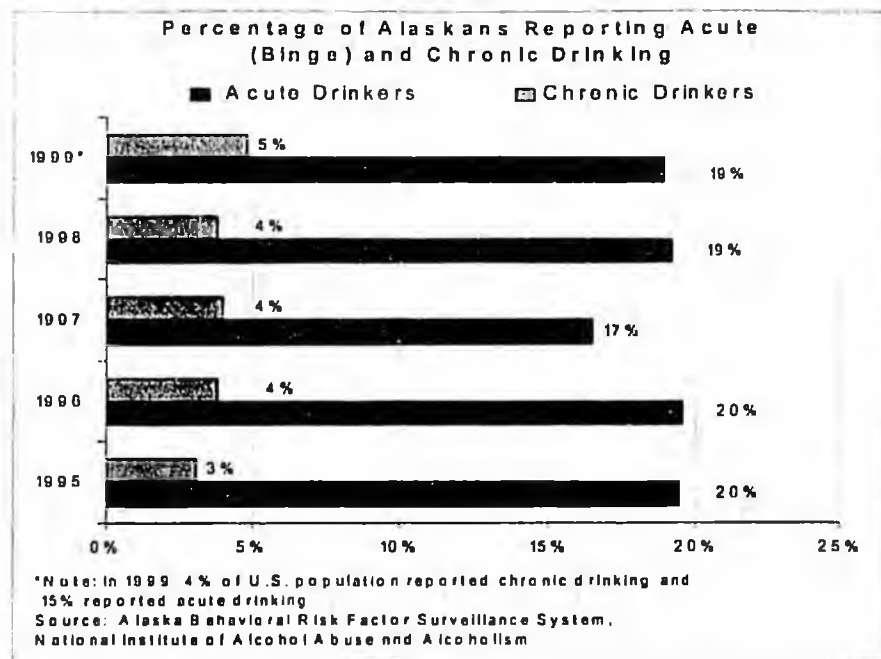
Healthy Alaskans 2010 targets:			
Substance Abuse	1999 Baseline	Target	
Increase Avg age of 1st use of alcohol	12.4	16.1	years old
Reduce binge drinking in grades 9-12	34%	30%	
Increase proportion grades 9-12 who do not use alcohol, marijuana or cocaine in the last 30 days	49%	60%	
Decrease the number of 9-12 graders who get in a vehicle with a driver who has been drinking	30%	20%	

The following charts show the drinking habits of Alaska adults (1995-1999) and youth (1999).



In 1999, according to Youth Risk Behavior Survey (YRBS) data, 46.9 % of high school students reported having had at least one drink of alcohol in the past 30 days. 34.4% reported at least one binge-drinking episode (five or more drinks in a row) in the past 30 days. (Anchorage students not included in the sample).

In 1995, according to YRBS data, 47.5% of high school students reported having had at least one drink of alcohol in the past 30 days. 31.3% reported at least one binge-drinking episode in the past 30 days. (Statewide sample)



In 1995 Alaskans reported 20% acute (binge) drinkers and 3% chronic drinkers in the Alaska Risk Behavior Factor Surveillance Survey.

Benchmark Comparison

US Baseline (1999)

- Reduce binge drinking among adults to 15%.

- Increase the proportion of adolescents (grades 9-12) not using alcohol (or illicit drugs) during the past 30 days to 46%.

Background and Strategies

Binge drinking, for the purposes of this survey, refers to drinking five or mores drinks on one occasion, at least once in the month preceding the survey. Chronic drinking refers to drinking an average of sixty or more alcoholic drinks in the month preceding the survey.

There is a high correlation between these drinking patterns and many of the negative consequences associated with alcohol abuse, particularly medical, family, and employment problems. Excessive alcohol intake is related to 4 of the 10 leading causes of death in the United States.

The YRBS is the survey tool that provides information on this measure for youth. The new active parental consent law for surveys increased significantly the burden on local school districts. A sufficient and reliable sample of the state's high school students could not be identified during 2001 under the active parental consent requirement (no figures are available for Anchorage).

The measurement of alcohol use among high school students may not be possible in the future, until another method can be devised. Efforts to reduce youth drinking are on-going and varied.

Division of Alcohol and Drug Abuse

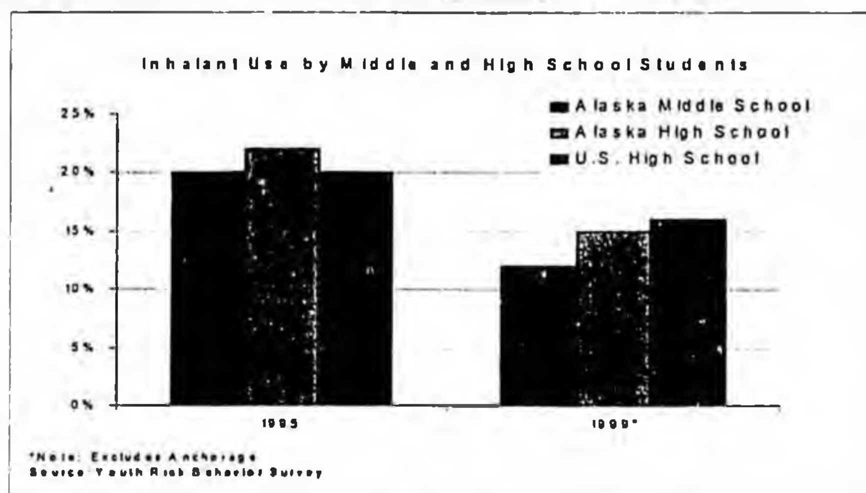
Measure

The rate of drug and inhalant abuse by age group and region.

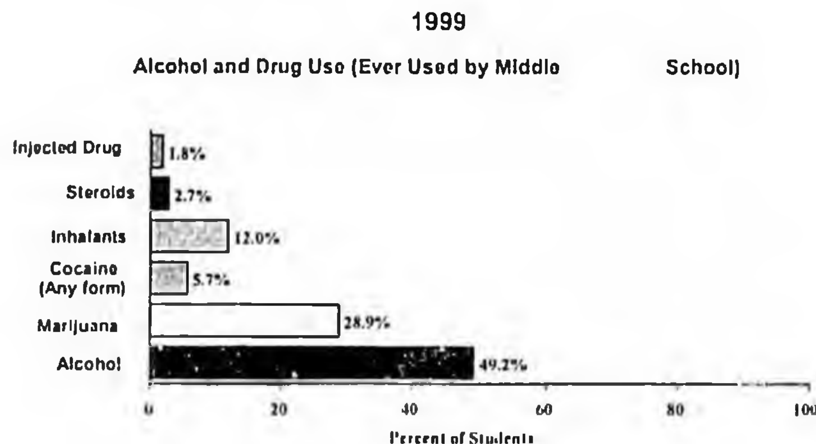
Sec 82(b)(2) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

In 1995, 22% of Alaska high school students reported that they had sniffed an inhalant to get high. In 1999, this percentage had dropped to 15%. This change may be the result of Anchorage not being a part of the 1999 Youth Risk Behavior Survey and is not to be taken as an actual drop in abuse by teenagers. According to the 1999 National "Monitoring the Future" study, 19.7 percent of students will have used inhalants at least once in their lifetime.



Twenty-two percent have used an inhalant by the time they have reached the eighth grade. At least 49 percent of middle school students have experimented with at least one type of drug or alcohol.



Background and Strategies

Nationally, 29% of those who use inhalants said they started before their 10th birthday. Communities don't know that inhalants, cheap, legal and accessible products, are as popular among primary and middle school students as marijuana. Even fewer know the deadly effects the poisons in these products have on the brain and body when they are inhaled or "huffed." Inhalants can cause permanent damage to the brain, heart, kidneys and liver, and can cause death. It's like playing Russian roulette. The user can die the 1st, 10th or 100th time a product is misused as an inhalant.

The Alaskan teen usage information is collected through the Youth Risk Behavior Survey. The sample that is drawn is meant to be representative of the State and is not designed to be broken out by region. We use the sampling methodology set forth by CDC so that our data is comparable to National data. The whole sampling methodology would have to be changed and would also have to be a much larger sample if we were to have regional data, and the data would not be comparable to National data.

The local school districts have the opportunity to collect school district data and some districts have done that in the past. Unfortunately, the Department doesn't have access to that data unless the school district releases it to us.

Division of Alcohol and Drug Abuse

Measure

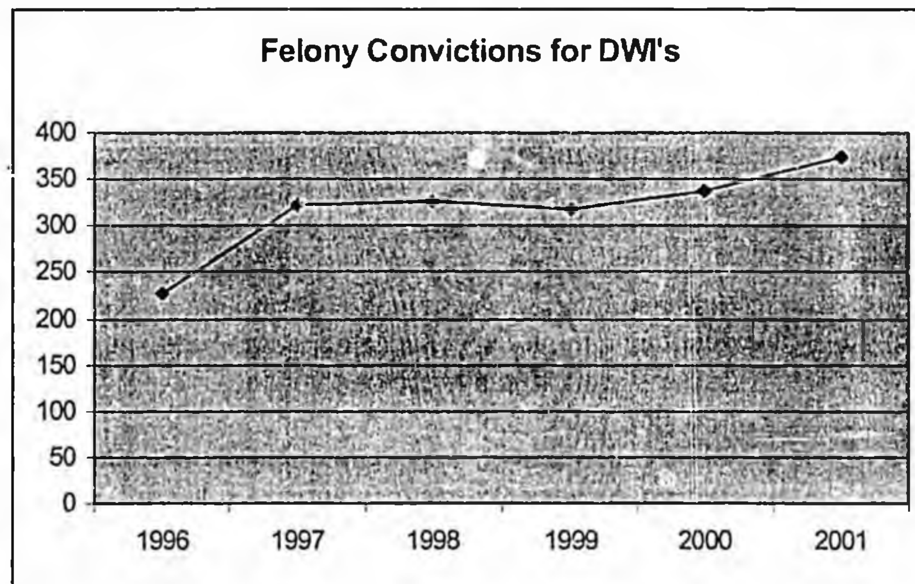
Number of new convictions and the number of repeat convictions in state district and superior courts on charges of driving while intoxicated (DWI).

Sec 82(b)(3) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

Felony DWI Case Convictions

FY1996	FY1997	FY1998	FY1999	FY2000	FY2001
227	322	326	317	337	373



Background and Strategies

Driving while under the influence of alcohol (DWI) is one of the strongest indicators of the negative consequences associated with alcohol misuse. Recent DWI data shows that approximately 45 - 48 percent of all automobile accident fatalities had alcohol or drugs as the major contributing factor. Driving while under the influence of alcohol impacts lives, not only in accidents, injuries, and deaths, but also in family suffering, employment problems, and social functioning.

Division of Alcohol and Drug Abuse

Measure

Number and rate of infants affected by prenatal exposure to alcohol by region.

Sec 82(b)(4) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

In October 2001, the Fetal Alcohol Syndrome (FAS) Surveillance Project released new FAS prevalence data for Alaska. At this time, only statewide data is being released, due to the small amount of data for some regions which provides a skewed representation of the true picture.

At this time, the FAS prevalence rate for the state is 1.4 per 1,000 live births and 12.6 per 1,000 live births for those at risk for some type of alcohol-related birth defect. These rates are higher than previously reported rates, but they are more accurate due to the increase in our ability to track.

Beginning in June of 2000, newly developed and trained FAS Diagnostic Teams began providing FAS diagnostic services. During FY01, 121 completed FAS diagnoses were performed in our first six communities. It is our expectation that with these increased services, we will see an increase in the number of reports to the Birth Defects Registry. We are currently analyzing the FAS Team data that has been submitted and will have regular reports as new data is provided.

Nine children, who were born in 1990, have been reported to the birth defects registry that were diagnosed as having been prenatally exposed to alcohol or with microcephally or small head.

Because so much of this data is newly tracked and we are continuing to develop the most appropriate methodologies for tracking this disability, we may need to add additional benchmark data as we make progress in better understanding the complexities of an FASD diagnosis and the diagnostic process.

Background and Strategies

Since 1998, the DHSS Office of FAS and the FAS Surveillance Project have been working in collaboration to establish accurate and reliable data regarding the number and rate of infants affected by prenatal exposure to alcohol, statewide as well as regionally. Prior to 1996, the state had no systematic process for collecting data on children born prenatally exposed to alcohol. Prenatal exposure to alcohol became a reportable birth defect/condition in 1998 through the Alaska Birth Defects Registry (ABDR). Unlike all other birth defects that must be reported within the first year following birth, alcohol-related birth defects (ARBD) can be reported up through the age of six.

In addition to not having a system for tracking alcohol-related birth defects,

until 1998 there were few options in the state for obtaining screening and diagnostic services for individuals suspected to have fetal alcohol spectrum disorders (FASD). Since 2000, the state has increased diagnostic services across the state, at the community level with the expectation that we will begin to see an increase in reporting to the Birth Defects Registry. Alaska's 5-year FAS Project has a number of planned activities and projects that will continue to increase public and community awareness about the dangers of drinking alcohol during pregnancy, increase services to individuals and families affected by FASD, and improve our state's overall efforts to prevent FASD and to improve services to families already affected by disabilities associated with prenatal alcohol exposure.

Division of Alcohol and Drug Abuse

Measure

Number of new admissions as a percentage of the total admissions to treatment programs for alcohol and drug abuse.

Sec 82(b)(5) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

In FY2001, the rate of new admissions (2,020) to total admissions to treatment (5,828) was 34.66%.

In FY2000, the ratio of new admissions to the total admissions for treatment was 38.65%. 7,048 clients were admitted to substance abuse treatment as reported in the division's statewide Management Information System (MIS). Of the total admissions, 2,724 were identified as new* admissions.

*New admission means never before admitted to the treatment system in the history of the MIS, which began in 1983.

Background and Strategies

Below are a few of the outcomes derived from Alaska's Chemical Dependency Treatment Outcome Study:

- *Both residential and outpatient program participants reported substantial decreases in legal problems one year post treatment. Criminal arrests, traffic arrests and motor vehicle accidents dropped. This yields overall societal benefits as a result of chemical dependency treatment by easing demands on already overburdened legal and insurance systems.*

- *Of Alaskan patients surveyed, 56 percent of those in outpatient programs abstained from alcohol for one year after treatment, compared to 42 percent of residential patients. Outpatients in the study received an average of 59 hours of care, while patients in residential programs received an average of 39 days of inpatient care.*

- *Documented reductions in hospitalizations and emergency care and outpatient care for chemical dependency patients support the notion that, following treatment there is a shifting away from costly hospital and emergency room "crisis" or urgent care, toward more timely and appropriate preventive or routine outpatient treatment.*

- *Employment rates changed dramatically from pretreatment through one year after treatment. Full-time employment increased from 30 percent before treatment to 45 percent at 12 months. Conversely, unemployment rates dropped from 45 percent to 24 percent.*

It is important to note, however that Alcoholism is a chronic, progressive, but treatable disease. As in all chronic diseases, relapse is a part of the disease process. A client being readmitted to treatment after a period of time in remission is not uncommon. Relapse is defined as "to regress after partial recovery from an illness."

Division of Alcohol and Drug Abuse

Measure

Length of time that alcohol or other drug treatment clients are on waiting lists before receiving services.

Sec 82(b)(6) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

The division is currently working with the grantees to provide the length of time that individual's are on a waitlist on a regular basis. As of July, 2001, the number of people on the wait-lists were:

Program	No. on Waitlist	Bed/Capacity Need
Women w/ Children	67	19
Adult Residential	123	40

. The needed bed/capacity for women with children was calculated based on an average of 100 days in treatment. (365 days per year/100 days per woman for treatment = 3.65 women per bed in one year; 61 women currently on the waitlist/3.65 women per bed = 16.71 beds/year).

Currently the Division's wait list for adult residential programs stands at 123. In addition the DOC states that up to 120 persons per year are discharged needing dual diagnosis residential care. These persons may or may not be on the wait list. This waitlist does not distinguish between levels of care needed. Within this population there is need for short-term, long-term and dual diagnosis treatment.

Average length of stay are:

Women's programs: 42 days
Women and Children's Programs: 107 days
Adult Long term residential: 63 days
Dual Diagnosis: 43 days
Adult short term residential: 27 days

Background and Strategies

One of the most important aspects of successful treatment is that person enters the program when they are physically, mentally and emotionally ready. If they are placed on a waiting list, the chances are that they will not get the treatment they need. The result of being on a wait list is that they risk losing the motivation that triggered them to seek out a treatment program in the first place.

Division of Mental Health and Developmental Disabilities

Mission

The mission of the Division of Mental Health and Developmental Disabilities is to improve and enhance the quality of life for consumers impacted by mental disorders or developmental disabilities.

Division of Mental Health and Developmental Disabilities

Measure

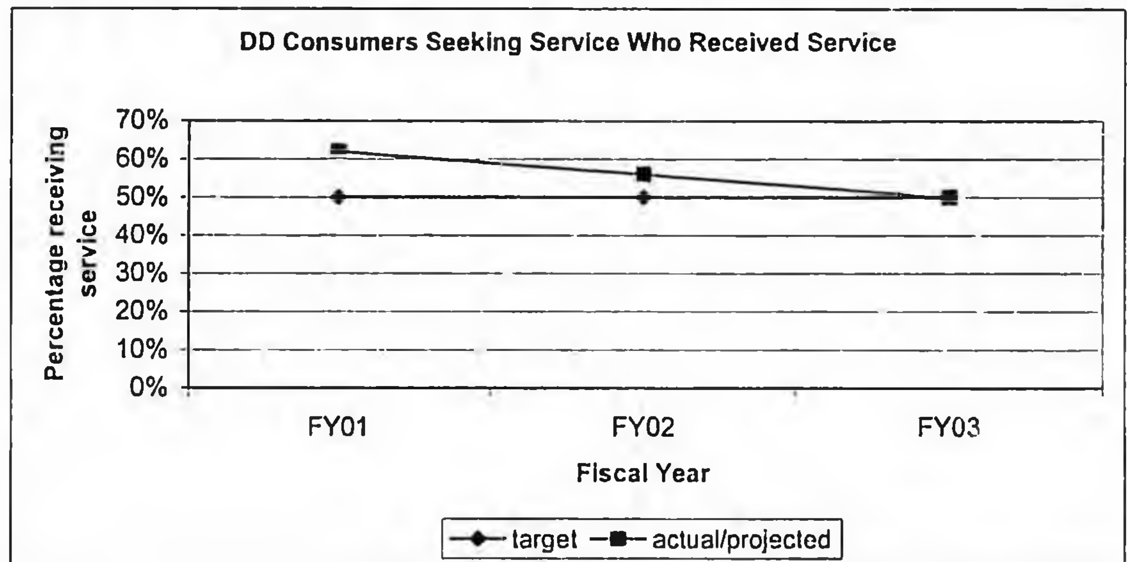
The percentage of those consumers who seek services for developmental disabilities who receive services at various levels from the division.

Sec 83(b)(1) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

The Developmental Disabilities (DD) Program target for the percentage of those consumers who seek services for developmental disabilities who receive services at various levels from the division is 50%. If the level of appropriation is maintained at its current amount and the waitlist continues to grow at its current pace, the percentage of consumers who seek services and who will receive services through grants will decline.

To receive funds under the DD program a person must be deemed eligible and be placed on the waitlist. By cross-referencing the waitlist with current program census information submitted by DD grantees, it was determined that 62% of the people on the waitlist in FY 01 received a service or support administered by DMHDD.



The performance measure represents those individuals who remain on the list while receiving services delivered by organizations across the state that receive DD Community Grants administered by the Division. Respite care, core services, or the purchase of special medical equipment are examples the type of assistance available to avert a crisis or delay the need for long-term care.

The measure does not relate to people who are selected and removed from the list to receive more comprehensive services. The measure also does not include individuals removed from the list as a result of obtaining comprehensive services or long-term care through Home and Community Based Waivers.

In prior years this data was collected as a raw total rather than a percentage. In FY00, 2,460 consumers received service through the program's grants and waivers, representing a 26% increase in one year. In FY99, 1,953 consumers received services through the program's grants and waivers.

Benchmark Comparison

No known Benchmarks or comparisons exist from other states or similar programs in Alaska. Of the 1,250 individuals on the waitlist as of September, only 251 were over the age of 22. Those younger than 22 are most likely receiving services through Infant Learning Programs (ages 0 – 3) or they are enrolled in special education (ages 3 - 22). While this may lessen the need for more comprehensive services, families report the need for additional supports to care for their children having DD. Also, it may represent good planning on the part of the family so their future needs can be considered.

Background and Strategies

The DD waitlist demographics and reasons for the growth in the waitlist are summarized in a waitlist report produced for the legislature each year on November 15. Basically, the waitlist grows as a function of improvements in medical technology and practice, population growth, and increased awareness of the benefits of DD services by families with young children. The capacity of provider organizations to deliver services to new people is limited by workforce shortages.

As the role of parents, particularly single parents, changes from being the child's primary care giver to becoming the sole source of income, the demand for paid supports to children with DD in the family expands. There are no readily-available institutional residences in Alaska for people with DD as there once were. Consequently, homes in the community must be developed before an individual can be placed with a provider. That process adds time for the person waiting for services.

Division of Mental Health and Developmental Disabilities

Measure

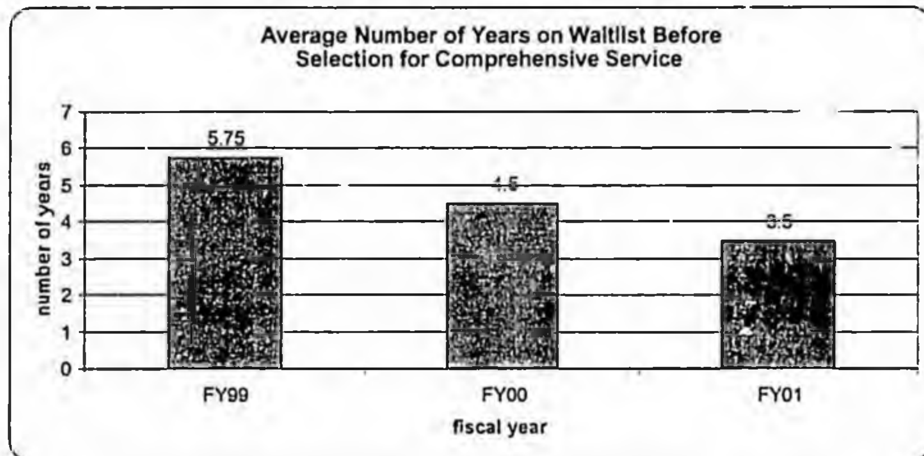
The average length of time that developmentally disabled consumers are on a waiting list before receiving full services.

Sec 83(b)(2) Ch 90 SLA 2001(HB 250)

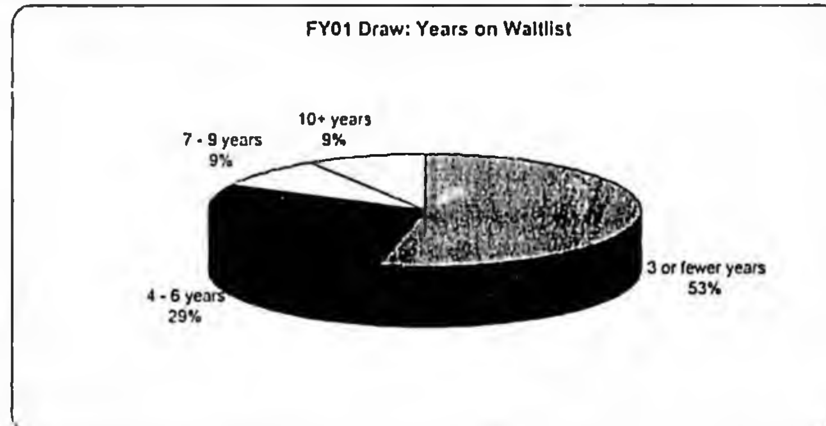
Alaska's Target and Progress

The target level for FY 03 for the average length of time that developmentally disabled consumers are on a waiting list before receiving full services is 4 years.

The waiting period in Alaska has been shrinking over the past 3 years, but that trend may not continue.



Of the 256 individuals removed from the waitlist to receive comprehensive or long-term care services in FY01, 53% had been on the list for less than 3 years.



Benchmark Comparison

Due to differences in the way states administer DD Programs and manage waiting lists, there are no known comparisons.

Background and Strategies

The length of time consumers remain on the waitlist is inversely proportionate to several factors: the growth of the Community DD Services budgetary appropriation, the increase in the number of Home and Community Based Waivers, and further development of service provider capacity. Without these increases, and due to the escalating number of consumers being added to the Waitlist, the average time before someone is selected for services will increase.

Measure

The percentage of mental health consumers receiving services who show improved functioning as a result of the services.

Sec 83(b)(3) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

There tends to be a difference in the rate at which children and adult mental health consumers improve as a result of receiving services. Early intervention does seem to have a greater impact. Alaska's targets are 20% for adults and 25% for children.

Based on aggregate data submissions for FY00 and FY01 by community mental health centers, we are achieving an improvement rate greater than expected:

MH Consumer Improvement

	total served	% improved
FY00 - Adults	10,110	40%
FY01 - Adults	10,507	38%
FY00 - Children	6,355	46%
FY01 - Children	6,396	53%

The Division collaborated with a University of Alaska Anchorage research team to develop several surveys that mental health clinicians could use with their patients. These tools measure a mental health consumer's functional level and can be used to make a comparison across time.

Background and Strategies

Given the serious nature of chronic mental illness, only limited sustained functional improvement can be expected. The focus of mental health treatment for consumers with the most severe challenge is to maintain their current level of functioning and to avoid the need for inpatient treatment.

The Division anticipates revising our targets for children and adult population as we move towards collecting individual service data, from which we can more accurately determine trend lines.

Division of Mental Health and Developmental Disabilities

Measure

The percentage of programs designated by the department that are reviewed for consumer satisfaction.

Sec 83(b)(4) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

The Division's target is to achieve and maintain at least a 50% annual review rate for agencies receiving grants through the division for direct client care.

In FY01, 41% of mental health service programs and 46% of developmental disabilities service programs were reviewed for consumer satisfaction. This contrasts with the FY99 data during which 49% of mental health programs and 34% of developmental disabilities programs were reviewed.

Background and Strategies

The target of reviewing 50% of the designated programs for in FY01 was not met due to the manner programs are identified for review each year. Integrated QA reviews occur in a two-year cycle. For the FY01 and 02 cycle there were a total of 44 programs selected for review. Twenty of these were selected for FY01 while 24 programs were selected for review in FY02. During FY01 one program was closed prior to the review being conducted and another was not reviewed due to their location (Aleutians) in relation to the cost associated with conducting an on-site review. This left 18 programs that were successfully reviewed. The most obvious choices for improvement are to 1) reduce the goal from 50% to a lower, more achievable goal or 2) calculate the number of programs in a manner that excludes those that weren't reviewed if a review was impossible or impractical.

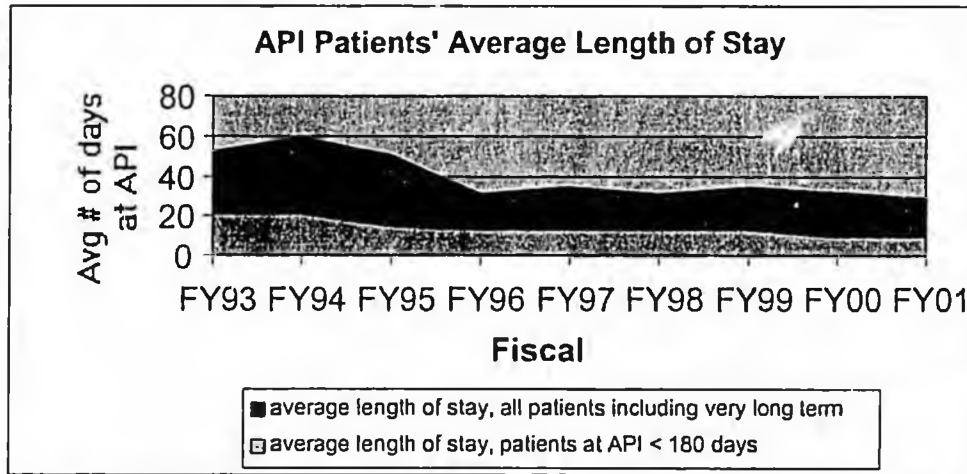
Measure

The average length of stay at the Alaska Psychiatric Institute.

Sec 83(b)(5) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

Significant data has been compiled on API over the past few years as a part of the evaluation of the federally-funded Community Mental Health/API Replacement Project. As a result, it has become clear that community mental health providers would prefer that API be able to retain patients experiencing chronic mental illnesses for longer periods of time, so that the patients were more adequately or fully stabilized prior to their discharge back to their community and the community mental health center (CMHC) program with which they are associated. These providers would clearly prefer an average length of stay (ALOS) of more than 10 days.



API's ALOS for FY01 was 10 days for persons at API with stays of 180 days of less. When you include all persons being treated at API, (including those with stays in excess of 180 days) the ALOS rises to 19 days. Since the number of persons at API with stays over 180 days totaled just 34, so it is clear that an ALOS of 10 days applies to the vast majority of the 1,544 patients admitted to API in FY01.

In FY01, API length of stay (LOS) data shows the following:

29% of all persons admitted were discharged from API within 1 day.
21% were discharged within two or three days
22% were discharged within four to 12 days
18% were discharged within 13 to 30 days
7% were discharged within 31 to 60 days
3% were discharged after 60 days.

Thus, 50% of all persons admitted to API were discharged within 3 days, many of whom were first-time admits with substance abuse as well as acute

psychiatric concerns at the time of admission.

Another 22% were discharged within 12 days. Hospitalizations of under two weeks are viewed as inadequate for some patients with chronic mental illnesses. From a CMHC's perspective, shorts stays not only fail to provide sufficient treatment time but also do not allow for adequate discharge planning between API, the patient, and the community provider.

While the State has not yet identified a specific target ALOS, given the comments of community mental health providers, it is clear that a goal of more than 10 days may be appropriate.

The increase in local capacity outside of Anchorage and the development of the Single Point of Entry in Anchorage at Providence Hospital will contribute to API's movement towards its goal of becoming a more tertiary care facility.

Benchmark Comparison

Good data on lengths of stay at other public psychiatric hospitals across the country does not exist. While a national database containing such data is presently under development through the auspices of the National Association of State Mental Health Program Director's Research Institute (NRI), NRI has not produced ALOS data for State psychiatric hospitals. The vast majority of public psychiatric hospitals in the nation are reporting a variety of performance measurement data to NRI, but lengths of stay is not yet one of the performance areas that the NRI is measuring.

Finally, API's very short ALOS is highly unusual for a state psychiatric hospital. The majority of public psychiatric hospitals do not accept emergency admissions, as API does

Office of the Commissioner

Mission

The mission of the Office of the Commissioner is to provide support and policy direction to the divisions within the department.

Office of the Commissioner

Measure

The percentage of divisions within the department that meet assigned performance measures.

Sec 84(b)(1) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

The Department of Health and Social Services has eight divisions which track and report on 48 legislatively assigned performance measures.

All divisions have reported on their assigned measures and continue to work toward meeting established targets and goals.

For newer measures, divisions continue to work on setting a target or goal.

Background and Strategies

Commissioner's Office

Measures

The average time taken to respond to complaints and questions that have been elevated to the Commissioner's Office.

Sec 84(b)(2) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

In FY2001, there were 126 questions and complaints logged into the Commissioner's Office Correspondence Tracking System. The average time to respond to these inquiries was 11 working days.

Division of Administrative Services

Mission

The mission of the Division of Administrative Services is to provide quality administrative services that support the department's programs.

Division of Administrative Services

Measure

The cost of Administrative Services personnel as compared to the cost of the entire Department's personnel.

Sec 85(b)1) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

	ADMIN SVCS/ COMM OFFICE	TOTAL DEPARTMENT	PERCENTAGE
FY00	$5,207.2	$121,253.9	4.29%
FY01	$5,855.3	$128,541.7	4.34%

Background and Strategies

Total costs (includes non-GF) associated with the Division of Administrative Services and the Commissioners Office are included in totals.

Division of Administrative Services

Measure

The percentage of grievances and complaints resolved without resort to arbitration.

Sec 85(b)(2) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress	In FY 2000 there were 131 cases and 98% were resolved without arbitration. In FY 2001 there were 74 cases and 97% were resolved without arbitration.
Background and Strategies	The number of cases declined from FY2000 to FY2001. This is partly due to the DHSS training that has been given to all supervisors.

Division of Administrative Services

Measure

The average number of days taken for vendor payments.

Sec 85(b)(3) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

FY2000 = 34 days
FY2001 = 33 days

Background and Strategies

It is important to note that the average payment days extracted from the accounting system start with the vendor's date listed on invoice. Therefore, the report extracted from the accounting system does not accurately reflect the days it takes a department fiscal office to process a vendor invoice.

Division of Administrative Services

Measure

The percentage of audit exceptions that are resolved.

Sec 85(b)(4) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress	In FY2000 a total of 6 audit exceptions occurred, all of which will be resolved by 6/30/2002.
Background and Strategies	The State Single Audits are one year behind. The data collected here will be one year later than other targets.

Healthy Alaskans 2010

Targets and Strategies for Improved Health

Volume I: Targets for Improved Health
Executive Summary

Alaska Department of Health & Social Services
Division of Public Health
December 2001

Healthy Alaskans 2010 Volume I: Targets for Improved Health
Executive Summary
December 2001

Alaska Department of Health and Social Services Steering Committee:
Jay Livey, MA, MBA – Commissioner
Janet Clarke – Director, Division of Administrative Services
Karen Pearson, MS – Director, Division of Public Health

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Healthy Alaskans 2010 Chapter Leads and Committee Members
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Healthy Alaskans 2010

Targets and Strategies for Improved Health

Volume I: Targets for Improved Health

Executive Summary - December 2001

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State of Alaska

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Department of Health & Social Services

Karen Pearson, Director
Division of Public Health

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We also wish to thank the staff in other Sections within the Division of Public Health who served as chapter leads, facilitated group discussions, and drafted text and tables for *Healthy Alaskans 2010*. Research staff, especially senior Research Analyst Phillip Mitchell, of the Bureau of Vital Statistics have been close partners. Staff of other divisions and departments, and health care provider and advocacy organizations provided information about programs, participated in meetings, and drafted sections. Greg Williams, State Demographer, provided essential population data.

Healthy Alaskans Partnership Council members and alternates, and agency staff who have attended meetings of the Council and numerous chapter-planning meetings, deserve credit for their commitment and contribution to the process.

Healthy Alaskans Partnership Council participants have included: Bill Allen, Donna Bacon, Mike Conway, Kathy Craft, Bettye Davis, Traci Davis, Laraine Derr, Joan Domnick, Charlie Fautin, JoAnn Hagen, Mark Hamilton, Auriella Hughes, Jewel Jones, James Jordan, Cheryl Kilgore, Cecile Lardon, Walter Majoros, Carmen Rosa D.C. Mallipudi, Christopher Mandregan, Bonnie McMahon, Peter Nakamura, Cynthia Navarrette, Brenda Norton, Karen Pearson, Richard Rainery, Rhonda Richtsmeier, Susan Rinker, Lisa Sadleir-Hart, Brian Saylor, Paul Sherry, Deborah Vo, Peter Wallis, Pam Watts, Kathryn Davey, Delisa Culpepper, Kristin Ryan, Jean Becker, Dee Blake, Robert Ruffner, Stan Steadman, Cindy Baldwin-Kitka, Laura Wertz-Stein, Nancy Merriman, Anne Henry, Diane MacMillan, Janet Clarke, Jay Livey, Tom Lefebvre, Bill Stokes, Kathryn Cohen, Susan Soule, and others.

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

TONY KNOWLES, GOVERNOR

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JUNEAU, ALASKA 99811-0601
PHONE: (907) 465-3030
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December 1, 2001

Dear Alaskans:

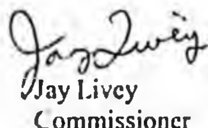
On behalf of the Alaska Department of Health and Social Services, the Division of Public Health is pleased to present *Healthy Alaskans 2010 Volume I: Targets for Improved Health – Executive Summary*. This first part of the Healthy Alaskans plan is the result of literally hundreds of hours of work by many individuals. Alaskans from rural and urban communities, Native organizations, state and federal agencies, and private businesses and organizations contributed their knowledge, experience and expertise to Healthy Alaskans 2010.

We are all aware that too many Alaskans are dying prematurely, suffering acute and extended illness and serious injuries, and living with long term disabilities. About half of these deaths and illnesses can be attributed to behavioral risk factors that can be changed. Healthy Alaskans 2010 is an important tool that can be used by organizations and communities to improve the health status of Alaskans, modify exposures to health risks, strengthen health care services, and reduce environmental and occupational hazards.

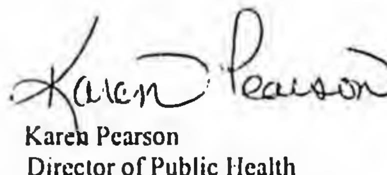
The Division of Public Health will use the Healthy Alaskans 2010 process to track changes in the health status of Alaskans over the next 10 years, serve as a framework for health policy development, identify the best indicators of health status, set ambitious but achievable targets, and ensure the information gained is shared with all partners.

We encourage you to use this plan and partner with us as we work toward improving the health of all Alaskans by the year 2010. Together we can achieve our goals of eliminating the health disparities that currently exist and ensuring that all Alaskans have reasonable access to quality care when needed.

Sincerely,



Jay Livey
Commissioner



Karen Pearson
Director of Public Health

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Introduction

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Introduction

What is Healthy Alaskans 2010?

Healthy Alaskans 2010 is a framework for realizing a vision: healthy Alaskans in healthy communities. It is a plan that includes a set of targets for 2010 that, if achieved, would reflect improved health status since 2000. A planning process involving participants from across the state has produced the following set of goals, selected indicators and targets for those indicators. These provide a framework for action at the local and state level, and a way to address new problems with new measures.

This Executive Summary contains the introductory chapter and overview from Volume I of the full report, as well as highlights of the chapters addressing twenty-six health topics in *Volume I: Targets for Improved Health of Alaskans.*

Volume II: Strategies for Improved Health will provide models and strategies for realizing the targets identified in Volume I. The third step in the planning process will be to outline action steps and policy recommendations for state government efforts to assist in achieving the targets.

Healthy Alaskans 2010 emerged from the Alaska Public Health Improvement Process, funded in part by the Robert Wood Johnson Turning Point grants. It is a state-focused adaptation of the national planning process called *Healthy People 2010*, sponsored by the United States Department of Health and Human Services.

The Alaska Department of Health and Social Services has reached out to develop partnerships for the review of needs and development of targets for improving health status and access to care. The Department requested that the Alaska Public Health Improvement Process Steering Committee guide the Healthy Alaskans 2010 planning process. With broader membership, the group is now established as the Healthy Alaskans Partnership Council. One of the Council's core principles is that broad community participation ensures local ownership. The community guides the process — collective thinking ultimately results in more sustainable solutions to complex problems and builds the experience for responding to emerging needs. Collaboration and partnership with communities, Native health organizations, and health care workers are considered essential to mobilizing the state for achieving goals for longer and healthier lives.

Engaging people and their communities to improve health status means that all members of the community – individuals and organizations — are public health partners. Local governments in Alaska are not mandated to assume responsibilities for public health but may do so through local ordinance. At the present time (2001) only the North Slope Borough and the municipality of Anchorage have health powers and offer services similar to city and county governments elsewhere. Regional Native health corporations, community health centers, hospitals, emergency medical personnel, as well as non-profit organizations and care providers all do health promotion and prevention work in addition to providing treatment services. They are key partners for improving health of the population.

Background

Alaska's people and communities cope daily with challenges to maintain health and well-being. Information about trends in health status suggests that Alaskans have been able to solve many of their health problems. For example, we have reduced injuries and illnesses related to weather, work settings, and geographical isolation of communities. But as a stronger health care and prevention system makes progress on old problems like tuberculosis, and as sanitation systems improve access to safe water and waste disposal, new challenges appear. Increases in obesity, diabetes, heart disease, "baby bottle tooth decay," and suicides point to a need for changes in how we eat, exercise, and care for one another. Many communities across the state are engaged in local efforts to improve their quality of life, the health of residents, and their economic base – they have demonstrated commitment to "healthy Alaskans in healthy communities."

Nationally, "healthy people in healthy communities" has become the theme of modern health planning, with an expectation that state and federal government efforts will support local initiatives for improving health. Public health, defined by the World Health Organization as "the science and organization of promoting health, preventing disease, and prolonging life through the organized efforts of society," works with community members and their leadership, health care professionals and organizations, employers, schools and universities, and others.

In the last decade, the Alaska Department of Health and Social Services (DHSS) developed state health objectives for the year 2000 based on *Healthy People 2000: National Health Promotion and Disease Prevention Objectives. Healthy Alaskans 2000*, published in

1994, presented a plan to assess the health status of Alaskans and identify key actions to be taken to make progress on certain health indicators in *Healthy People 2000's* Priority Health Areas.[1] In 1998 and in 2000, DHSS published reports on measurable progress toward the objectives, in the document "*Health Status of Alaskans.*" (see www.hss.state.ak.us/dph/deu/publications/publications.html)

Entering the new century, a national process set new health objectives for the nation. *Healthy People 2010:The National Health Promotion and Disease Prevention Initiative* provides an updated set of goals and new measures of health status. The new national document emphasizes links between individual health and community health. The physical and social environments in which people live, work, and play need to be taken into account. Beliefs, attitudes, and behaviors of everyone who lives in the community affect others and the community as a whole.

The national *Healthy People 2010*, like its predecessor, was developed through a broad consultation process, built on the best scientific knowledge and designed to measure trends over time. The two overarching goals of *Healthy People 2010* are:

- To help individuals of all ages increase life expectancy and improve their quality of life.
- To eliminate health disparities among different segments of the population.

Many states, including Alaska, have taken the opportunity to relate the national framework to their own issues. *Healthy Alaskans 2010 Volume I: Targets for Improved Health* will be used over the decade to track changes in health status of Alaskans. It serves as a framework for health policy development. It reflects Alaskans' priorities and objectives for improving health status, modifying exposures to health risks, strengthening health care services, and reducing environmental and occupational hazards. The twenty-six problem-specific chapters have been completed by the staff of DHSS, with assistance from other state agencies and from other health care organizations. The objectives and targets for each chapter were presented at a full-day workshop following the Alaska Public Health Association's December 2000 Health Summit.

The second volume, *Healthy Alaskans 2010 Volume II: Strategies for Improved Health*, identifies those strategies for action to achieve the goals and objectives for health set in *Volume I: Targets for Improved Health*. *The Department of Health and Social Services Healthy Alaskans 2010 Action Plan* will include steps DHSS will take to implement the strategic plan and reach the targets set for this decade. The action plan in Volume II will serve as a roadmap to a healthier Alaska, providing guidance for state action and services and for partners in this endeavor.

Purpose and Use of this Plan

Healthy Alaskans 2010 Volume I will:

- Serve as a framework for health policy development
- Identify best indicators of health status
- Provide a basis for tracking changes in health status of Alaskans over the next decade
- Set ambitious but achievable targets

The health status of a population can be tracked, analyzed, and improved through public health programs once a baseline point of reference is identified. The baseline may be the death rate, disease incidence or prevalence rate among a certain group of people. Trends in individual behaviors like smoking and binge drinking that can affect health in the short or long term can be measured through population-based sample surveys such as the Behavioral Risk Factor Surveillance Survey. Environmental conditions that are protective of good health or that pose threats to good health can also be tracked. The indicators recommended for tracking over the decade include all three types of measures: health status, behaviors that can affect health and wellness, and environmental factors. The indicators also include inventories of services, workforce, communications capabilities, and specific capacities of the public health infrastructure and the health services delivery system.

How to Use this Document

Following the introduction, *Healthy Alaskans 2010 Volume I* is divided into four main sections:

- Health Promotion
- Health Protection
- Preventive Services and Access to Care
- Public Health Infrastructure

Within each of these broad cluster areas are chapters (or focus areas) on more specific topics related to sets of health conditions or risk or protective factors

(see Table 1). The groupings reflect important conceptual common themes, but many chapters could have been included in another section as well. Cross references are provided in the appendices to Volume I. For example, the "tobacco use" chapter is included in the health promotion section, because of the current focus on developing awareness, discouraging early smoking, and encouraging smoking cessation, although some of the strategies for prevention include non-smoking ordinances for public places, tobacco taxes, and other options for state or local regulations that fall into the category of "health protection."

Table 1. Healthy Alaskans 2010 Focus Areas

Health Promotion	
1. Physical Activity and Fitness	5. Mental Health
2. Nutrition and Overweight	6. Educational and Community-based Programs
3. Tobacco Use	7. Health Communication
4. Substance Abuse	
Health Protection	
8. Injury Prevention	12. Food Safety
9. Violence and Abuse Prevention	13. Oral Health
10. Occupational Safety and Health	14. Vision and Hearing
11. Environmental Health	
PREVENTIVE SERVICES AND ACCESS TO CARE	
15. Access to Quality Health Care	21. Heart Disease and Stroke
16. Maternal, Infant, and Child Health	22. Cancer
17. Family Planning	23. Diabetes
18. Immunizations and Infectious Diseases	24. Respiratory Diseases
19. HIV Infection and Sexually Transmitted Diseases	25. Disability and Secondary Conditions
20. Arthritis and Osteoporosis	
PUBLIC HEALTH INFRASTRUCTURE	
26. Public Health Infrastructure and Preparedness	• Public Health Workforce
• Information and Data Systems	• Organizational Capabilities

Each chapter includes:

- **Health goal for the year 2010**
- **Health Indicators and Targets for the Year 2010 – Table**

Health indicators for 2010 are listed with the Alaska data source, the U.S. baseline data that corresponds to the Alaska data source, and the Alaska baseline and target for 2010. 1999 data is used as the baseline when available. In some cases, Alaska baselines for the indicators were not available at the time of this report. In those cases, efforts are needed to develop a system to collect baseline information, and the indicator is described as "developmental". The national baselines, usually from *Healthy People 2010*, are meant to offer the reader a comparison of Alaska's health status.

In some cases, we have calculated a national baseline from a source that provides a better comparison to the Alaska baseline than the *Healthy People 2010* data source for the national measure. For example, for the national process, surveys may be available that provide information for the nation as a whole, but may not be able to provide reliable estimates for individual states.

For each indicator, the target for the year 2010 is noted. Targets represent a consensus of opinion from people in the field of where we want to be in 2010. They are meant to be a focus for action and to allow a meaningful way to measure and evaluate progress on the specific indicator.

- **Chapter Narrative**

Chapter narratives include:

- *Overview*—Basic information is presented on particular issues as well as national statistics and trends.

- *Issues and Trends in Alaska* — The issue or disease is described as it pertains to the health of Alaskans. This includes information on the extent of the problems in Alaska, including differences in groups by age, sex, race, and socioeconomic status, and trends as they relate to these health problems. Regional differ ences are not emphasized in this document (although they are noted in some chapters); however, data on geographical subdivisions are expected to be tracked where feasible in subsequent documents such as the periodic report on health status in Alaska.

- *Current Strategies and Resources* — This section describes programs and activities that deal with the health problems and diseases that are the focus of the chapter. Many of the programs described are state-funded or state-managed programs. Where community initiatives or Native Health Corporation programs were identified, they are summarized. However, the authors recognize that the list of current efforts for each chapter provides a partial overview rather than a comprehensive inventory of prevention, treatment, and rehabilitation activities.

- *Data Issues and Needs* — Major data gaps exist which restrict our ability to assess and monitor progress toward health goals. The Alaska baselines are sometimes the "best data available" that have to serve in the place of the data actually needed. In some cases, there is no established data source and thus the indicator is considered "developmental." This section discusses the most critical data needs for the specific health problem or behavior.

- *Related Focus Areas* — This section acknowledges that most efforts to improve health status impact people's lives in many ways—improvement in one area may well improve other areas of health. Some chapters such as Education and Community-based Programs, Access to Quality Care, and Health Communication have links with all the chapters in Healthy Alaskans 2010.

Healthy Alaskans 2010 as a Work in Progress

Healthy Alaskans 2010 was developed through a participatory process. Numerous State of Alaska employees assisted by proposing health indicators and targets and by writing narratives. Some chapters had attention from a larger group of contributors than others because established governmental or public-private collaborative advisory committees already existed on certain health problems. The result is that many chapters focus on State of Alaska activities and strategies, rather than on non-governmental and community activities. A number of methods for soliciting advice and comment were used: Healthy Alaskans 2010 indicators and targets were posted on the internet for a year, chapter drafts were posted and circulated to key contacts, and presentations were made at numerous meetings.

How to Use Healthy Alaskans 2010 Volume II: Strategies for Improved Health

Volume II, to be published in 2002, will be a resource for examples of model programs, "best practice" guide-lines, and tools or performance measures that have worked in Alaska settings or show promise for being useful to Alaskan communities, employers, health care providers, educational institutions, and program managers as they seek to improve the health of the population. Appendices will include summaries and contact information about disease-specific planning documents and organizational strategic plans from Alaska's many partners working for improved health. Additional references to data, grant programs, and model programs and practices will be listed. An Action Plan for the DHSS will identify programmatic and policy initiatives identified by the review of strategic issues, options and targets.

Introduction

[1] Efforts recommended and supported by the plan included passage of the tobacco excise tax (passed October 1, 1997), and introduction or continuation of several data collection efforts (behavior risk factor surveillance, pregnancy risk assessment monitoring, trauma registry, traumatic brain injury registry, cancer registry, birth defects registry, and updated and expanded disease reporting in immunization programs).

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Section of Community Health and Emergency Medical Services. Alaska trauma registry. (unpublished data). Alaska Department of Health and Social Services, Division of Public Health; 2001.

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U.S. Department of Health and Social Services. Healthy People 2010 (Conference Edition, in two volumes). Washington DC; 2000.

Williams, G. Alaska population overview: 1999 estimates. Alaska Department of Labor and Workforce Development; 2000.

Key Websites for Reference and Data

2000 Census Data for Alaska www.labor.state.ak.us/research/cgin/cen2000.htm
AK Info www.ak.org
Alaska Native Health Board www.anhb.org
Alaska Native Tribal Health Consortium www.anthc.org
Centers for Disease Control www.cdc.gov
MAPP/Mobilizing for Action through Planning and Partnerships www.naccho.org/tools.cfm
Medline Plus, National Library of Medicine www.nlm.nih.gov/medlineplus/healthtopics.html
Municipality of Anchorage Department of Health and Human Services www.ci.anchorage.ak.us/Health
State of Alaska www.state.ak.us
State of Alaska Department of Health and Social Services www.h[illegible]state.ak.us
Turning Point Alaska www.turningpointprogram.org/Pages/ak.html
U.S. Census Bureau www.census.gov

Overview of Alaska and the Health Status of the Population

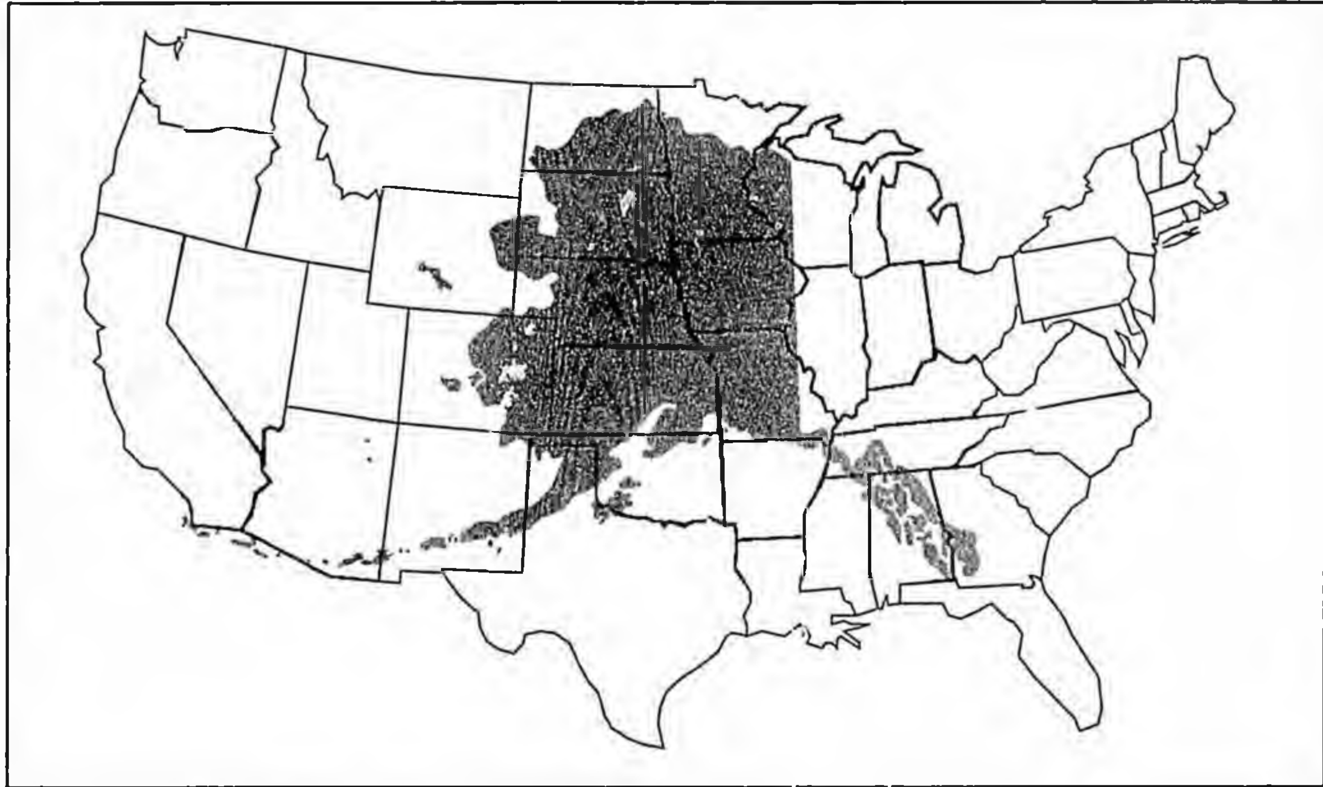
- The State and its Population
- Births, Deaths – Leading Causes
- Protective Factors and Risk Factors
- Leading Health Indicators
- The Challenge to Eliminate Heath Disparities

Overview of Alaska and the Health Status of the Population

The State and Its Population

Alaska is the largest state, encompassing an area about one fifth of the total landmass of the contiguous United States. There are huge variations in topography and climate from one part of the state to the other.

Figure 1



Alaska's name is derived from the Aleut word *Alyeska*, meaning "great land." In much of Alaska, the earth at variable depths beneath the surface remains frozen permanently. This permafrost defines most construction technology, including wells and sanitation systems for many rural residents.

The State of Alaska encompasses 571,951 square miles of land. It is 1,400 miles long and 2,700 miles wide, with over 47,000 miles of coastline. Of the 20 highest peaks in the United States, 17 are located in Alaska, including Mt. McKinley which is the highest point in North America. Glaciers cover 10 percent of the land. The state is comprised of both organized boroughs and census areas. As of July 1, 2001, there were 16 organized boroughs, which are equivalent to county governments in other states. The area not in an organized borough, the remainder of the land, is administered by the State, and is divided into 11 census areas for statistical purposes. Census areas and boroughs are considered county equivalents by the federal government for federal statistical and program purposes.[1] Although many of the census area boundaries tend to follow Native regional corporation boundaries, they are not all congruent. Native health corporations have service areas that are roughly overlapping with Native regional corporation areas, but the Native health corporations in fact serve populations, not geographically defined areas.

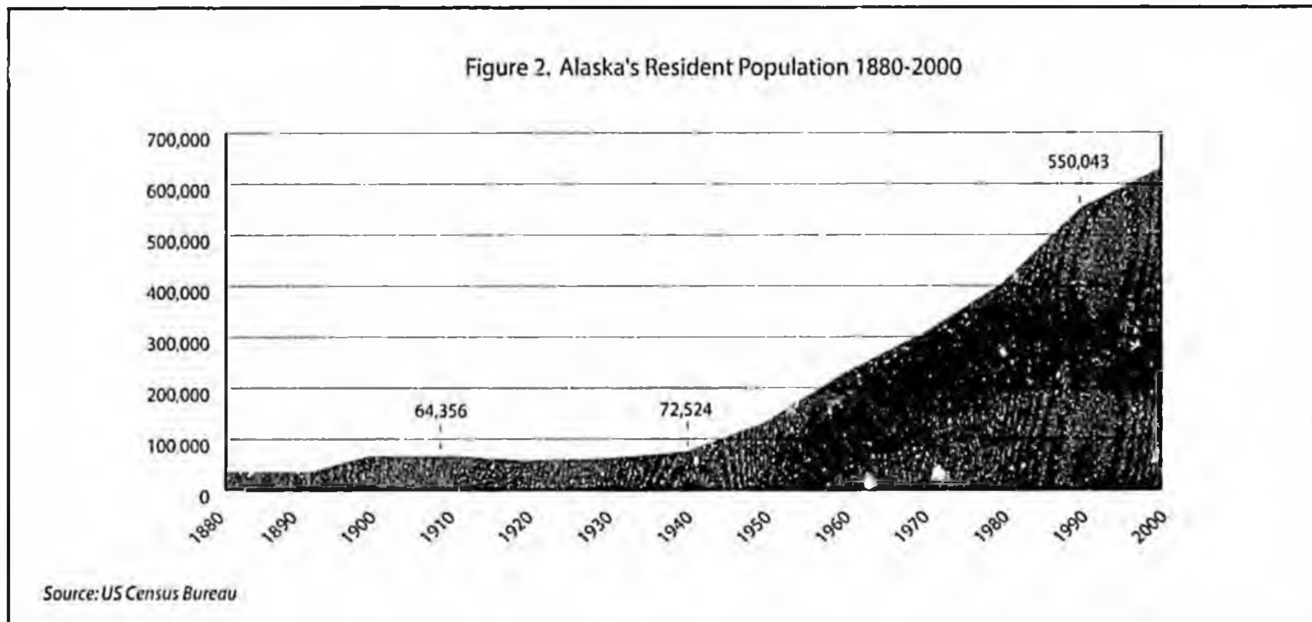
The 2000 census found Alaska's population to be 626,932 persons; Alaska ranked 48th in population in the United States with only Wyoming and Vermont having fewer people (Table 2 & Figure 2).

Table 2. Healthy Alaskans Comparisonss between Alaska and the United States, 2000

	Alaska	United States
Population	629,932	281,421,906
Population, percent change, 1990 to 2000	14%	13%
Persons per household	2.74	2.59
Land area (square miles)	571,951	3,537,441
Persons per square mile	1.1	79.6

Data Source: US Census

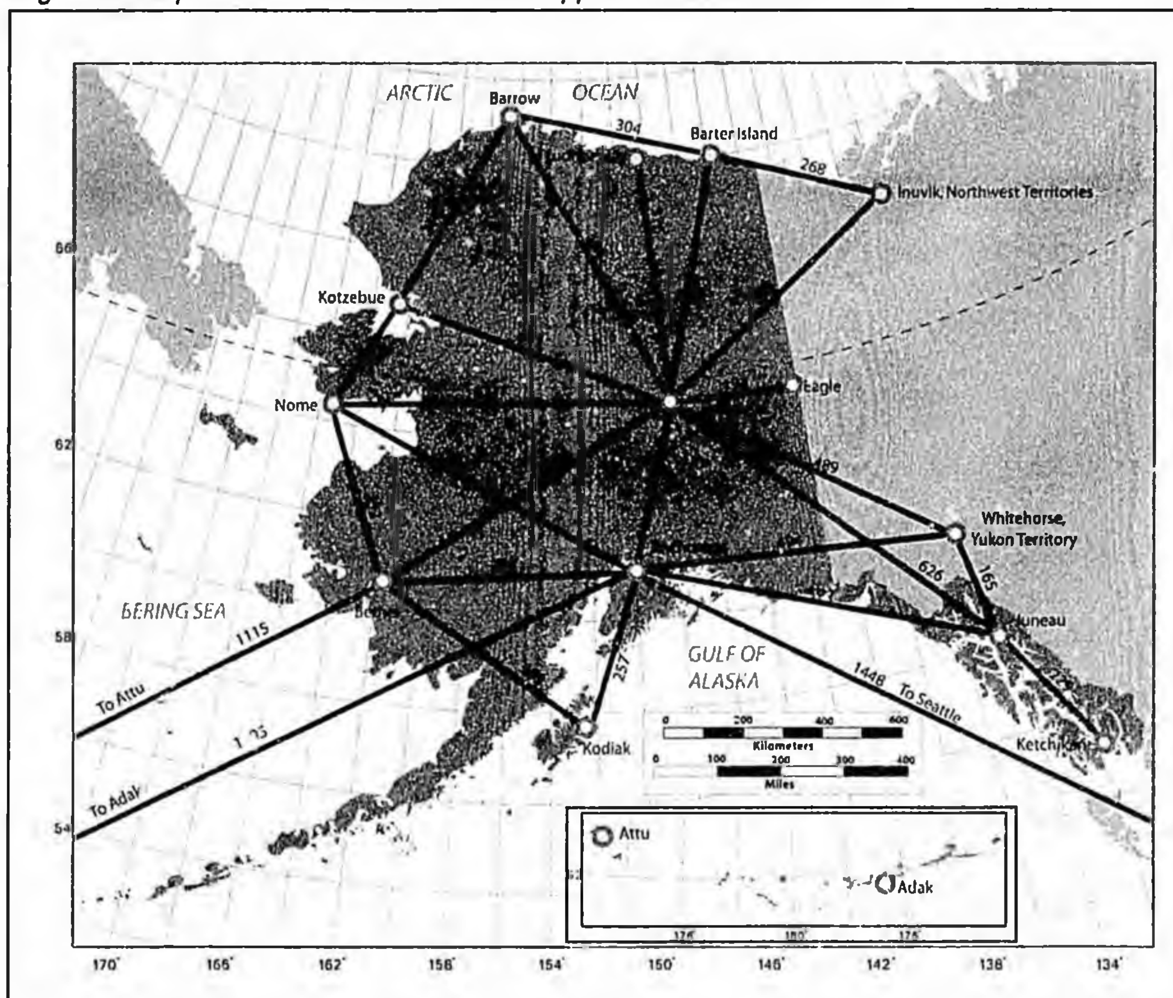
The population in Alaska increased dramatically beginning in the 1940s when the road construction and military operations began (Figure 2), and continued into the 1950s.[2] The rate of growth slowed in the 1990s, to a rate very slightly higher than growth throughout the United States. Although this document ca‥ ‥ provide in-depth history of the people of Alaska, or of the economic and natural history of the state, it is very i‥ ortant to consider the history, culture, geography and environment in order to reach a better understandin of past, current and future health status of Alaskans. Please see footnotes and reference lists for additional r‥ sources.



Despite Alaska's low population density (1.1 people per square mile), more than 7 out of 10 persons live in places of 2,500 people or more (defined as urban places by the Census Bureau). Forty one percent of the population resides in Anchorage, and 79% of the population resides in the six largest census areas: Anchorage, Fairbanks, the Kenai Peninsula, Ketchikan, the Matanuska-Susitna Borough, and Juneau.

About 30% of the population live in "rural" places – less than 2,500 residents or outside any community. Approximately 72% of the state's population lives in areas that are for the most part connected by the highway system to Canada and the lower 48. The remainder of the population live in so-called "roadless" areas where access to the major urban centers of Alaska or to the lower 48, including hospitals, is only by air, boat, or snow machine, making travel difficult, expensive, and hazardous. In order to receive primary, preventive, or emergency health care, many rural Alaskans must wait for clear weather to schedule a trip to an urban center, if they are able to pay for transportation. (See Figure 3, Map of Distances within Alaska.)

Figure 3. Map of Distances within Alaska Approximate Air Miles



The two largest racial groups in Alaska are White and Alaskan Native (Figures 4 and 5).[3] The 2000 U.S. Census allowed individuals to report multiple races as well as ethnicity, making it difficult to compare the racial data for 1990 with racial data for 2000. Defining the term "race" has always been somewhat arbitrary. "The tendency today to define race by a people's culture, history and way of life blurs the distinction between race and nationality or ethnicity."[4] Because "race" is used by federal programs and by the federal Office of Civil Rights and by states, localities and programs to track service delivery to target populations and disparities in health status, it is necessary to develop comparable data.

Comparing Alaska to the nation as a whole shows that twice the proportion of Alaskans reported more than one race (5.4% of Alaskans compared to 2.4% of all U.S. residents), as shown in Figure 4. When the 34,146 respondents who answered that they were multi-racial or of "some other race" are distributed to the five major groupings using the equal proportion bridge series (see Appendix D for details on the method), the patterns of change for the various racial groups since 1990 can be observed.

As shown in Figure 5, between 1990 and 2000 the share of the population that is American Indian and Alaska Native increased from 15.7% of the total to 17.7% of the total, and the share that is Asian or Native Hawaiian and Pacific Islander increased from 3.7% to 5.6%. Although the Black or African American population increased by 2,714 individuals, the share decreased from 4.2% to 4.1%, and the proportion of the population that is White dropped from 76.5% to 72.6%.

Table 3. Alaska Population by Race, 1990 and 2000

	1990 Census MARS* Number	Census Equal Proportion "BridgeSeries" MARS Estimate Number
Total Population	550,043	626,932
White	420,745	455,284
American Indian and Alaska Native	86,252	111,091
Black or African American	22,833	25,547
Asian and Pacific Islander	20,213	35,010
Asian	—	30,352
Native Hawaiian and Pacific Islander	—	4,658

*Modified Age Race Sex file data from the US Bureau of the Census; used as the basis for population estimates and projections.
Source: Greg Williams, Race and Ethnicity in Alaska, Alaska Economic Trends, Oct. 2001.

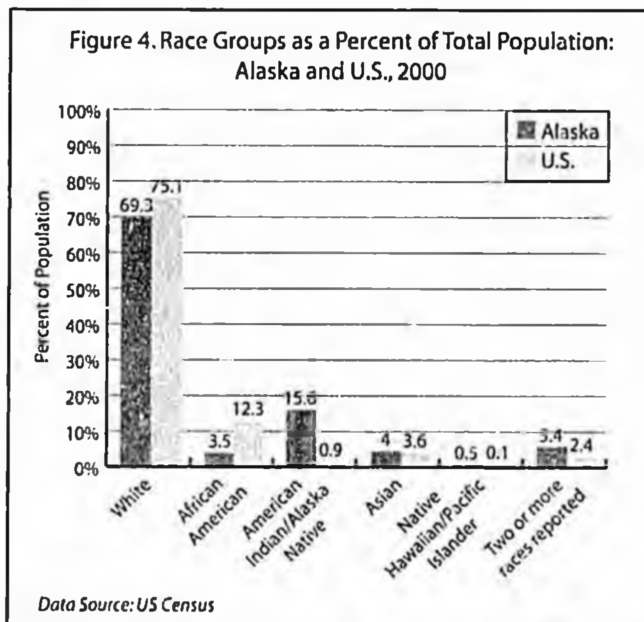


Figure 4. Race Groups as a Percent of Total Population: Alaska and U.S., 2000

Data Source: US Census

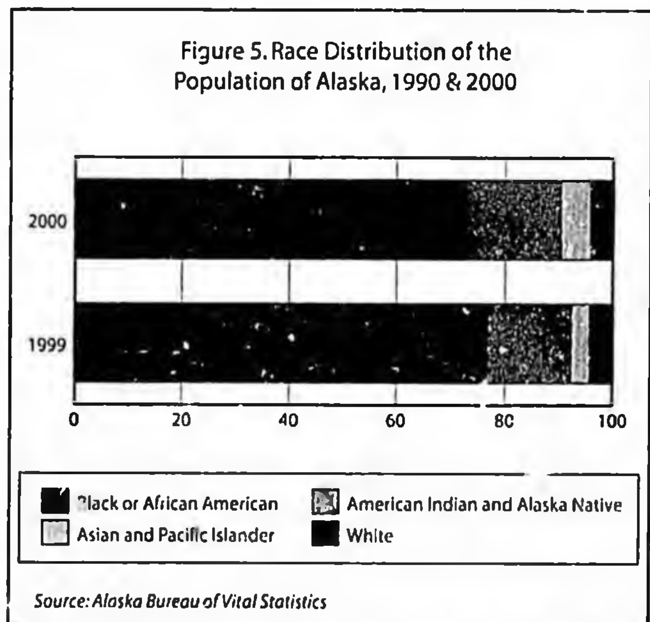
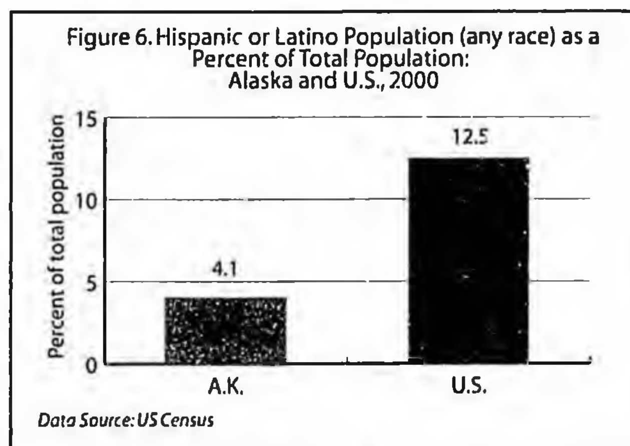
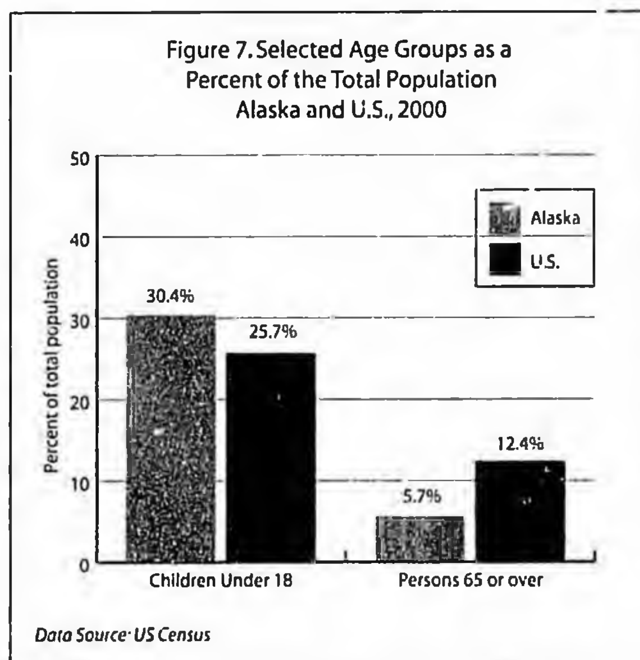


Figure 5. Race Distribution of the Population of Alaska, 1990 & 2000

Source: Alaska Bureau of Vital Statistics

The Hispanic population can be of any race. The proportion of the population responding that they are Hispanic or Latino is much smaller in Alaska than in the rest of the United States (Figure 6). In 1990, 3.2% of the population reported being of Hispanic origin (17, 803 people), while in the 2000 census, 25,852 individuals or 4.1% of the population reported being Hispanic or Latino.





Alaska's population is younger than that of the United States (Figure 7). Although 30.4% of the population is children under 18, compared with 25.7 percent of the U.S. as a whole, in 1990 31.4% of the population was under 18. The population is "aging" as fertility rates are declining, and mortality rates continue to decline. The population aged 65 and over has increased from 22,095 to 35,699 (an increase from 4.0% to 5.7%).

In 2000, the median age in the U.S. was 35.6 years, while the median age for Alaska was 32.4 years. The gap between Alaska and the U.S. is narrowing. Alaska's median age increased from 29.3 years in 1990 to 32.4 years includes the nation's youngest census area, Wade-Hampton, where the median age is 20.0. Historically, the reason for Alaska's young population is a large "bulge" in the working age population of ages 30-54, and a corresponding increase in children of this working group. The ages 55-64 years have traditionally been the ages at which many Alaskans begin to move south.[6]

Births

There are close to 10,000 births each year in Alaska. Alaska's fertility rate (the number of live births per 1,000 women aged 15 to 44) is higher than the national average (Table 4).

Table 4. 1999 Births, Alaska and U.S.

	Alaska	US
Teen birth rate (15-19)	47.8	49.6
Fertility rate (births per 1000 women 15-44)	72.5	65.9
Adequate prenatal care (APNCU Index)	67.1%	74.7%
Pre-term births	10.8%	11.8%
Low birth weight (less than 2500g)	5.7%	7.6%

Overall, birth outcomes in Alaska compare favorably with U.S. statistics (Figure 8). The pre-term birth rate and low birth weight rate are both lower than national rates. In recent years, Alaska has had one of the lowest rates of low birth weight deliveries in the nation.

Significant statistical differences between Alaska Natives and all Alaskans continue. Alaska Native women have higher fertility rates, higher teen birth rates, and lower rates of adequate prenatal care (Table 6).

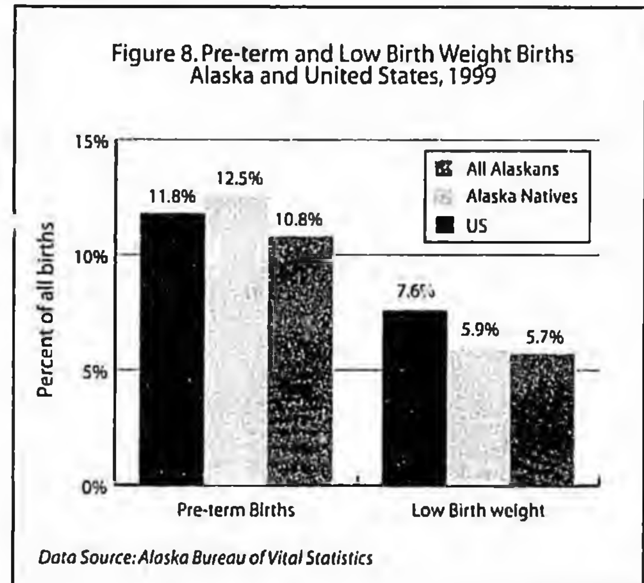


Table 6. 1999 Births, All Alaskans and Alaska Natives 1999 Births in Alaska

	All Alaskans	Alaskan Natives
Total births	9,959	2,461
Teen birth rate (15-19)	47.8	85.8
Fertility rate (15-44)	72.5	106
Adequate prenatal care	67.1%	47.2%
Pre-term births	10.8%	12.5%
Low birth weight	5.7%	5.9%

Deaths — Leading Causes

Mortality patterns provide insight into changes in the health and well being of Alaska's population. Wherever possible in this document, 1999 is considered the baseline from which change is measured. Future tracking through the decade will help identify segments of the population at increased risk of death from specific diseases and injuries. Changes and trends within the leading causes of death can highlight disparities in death rates among demographic groups, including racial and ethnic groups, which reflect group differences in factors such as socioeconomic status, access to medical care, and prevalence of risk behaviors specific to a particular population.

The ten leading causes of death accounted for about 78% of all deaths in Alaska in 1999. Table 7 shows the leading causes with corresponding rank for the specific causes in the U.S. Leading causes of death in Alaska differ in rank order from the U.S. list. Four of the causes in Alaska's top 15 did not even make the U.S. list. Other important differences include:

- Unintentional Injuries ranked 3rd in Alaska and 5th in the U.S.;
- Suicide ranked 6th in Alaska 11th in the U.S., and
- Homicide ranked 8th in Alaska and 14th in the U.S.

Table 7. 10 Leading Causes of Death in Alaska, 1999 (cause of death codes using ICD-10)

	Alaska Rank[1]	U.S. Rank	Alaska Total Deaths	Alaska Percent of Total Deaths	Alaska Age Adjusted Death Rate[2]
Malignant Neoplasms - Cancer (C00-C97)	1	2	623	23.1	192.7
Diseases of the Heart (I00 -I09,I11,I13,I20 -I51)	2	1	560	20.8	206.6
Unintentional Injuries (V01-X59,Y85-Y86)	3	5	289	10.7	56.1
Cerebrovascular Diseases (Stroke) (I60-I69)	4	3	172	6.4	75.4
Chronic Lower Respiratory Diseases (J40-J47)	5	4	145	5.4	58.6
Suicide (X60-X84,Y870)	6	11	95	3.5	17.2
Diabetes Mellitus (E10-E14)	7	6	66	2.4	24.8
Homicide (X85-Y09,Y871)	8	14	50	1.9	8.1
Influenza and Pneumonia (J10-J18)	9	7	45	1.7	21.2
Chronic Liver Disease and Cirrhosis (K70,K73-K74)	10	12	42	1.6	9.1
Total, Ten Leading Causes			2087	77.5	669.7
Total, All Causes			2698	100.0	869.8

[1]Rank is based on the number of deaths rather than rate

[2]Deaths per 100,000, age adjusted to the 2000 standard population

Protective Factors and Risk Factors for Death, Disease and Disability

In Alaska the Youth Risk Behavior Survey (YRBS) and the Behavioral Risk Factor Surveillance System (BRFSS) are conducted in partnership with the federal Centers for Disease Control and Prevention to determine various risk factors for poor health outcomes. Risky lifestyle behaviors are often associated with premature morbidity and mortality. The BRFSS estimates the prevalence of behavioral risk factors in the general population by conducting a random sampling by telephone in five regions based on common demographics, with over-sampling from the non-urban areas of Alaska, in order to have a sufficient sample for the less populated regions. The five regions are Anchorage and vicinity, Gulf Coast, Southeast, Rural, and Fairbanks and vicinity.

The BRFSS covers questions on alcohol use, tobacco use, nutrition, physical activity, health care access, family planning, and a variety of other topics. Figure 9 lists results for adults 18 years and older from the 1999 BRFSS for selected questions. "Adults who are physically inactive" refers to those who report no leisure time activity in the past 30 days. Alaska adults are more active than the overall U.S. population (24% respond they are inactive as opposed to 28% for the U.S.); however, when looking at reports of inactivity and irregular activity for Alaskans, this percent increases to 52%. Regular physical activity reduces premature death and greatly reduces the risk of dying from heart disease, the second leading cause of death in Alaska.

Adults who meet criteria for "overweight" are those with a body mass index of 25.0 - 29.9 kg/m^2. In Alaska we have a slightly more overweight population than in the U.S. (Figure 9).

Alaska has a higher proportion of adults who binge drink and smoke cigarettes (Figure 9). "Binge or acute drinking" is defined as consuming five or more drinks on one occasion within the past 30 day period, and "cigarette smoking" is defined as those who have smoked at least 1000 cigarettes in their entire life and smoke

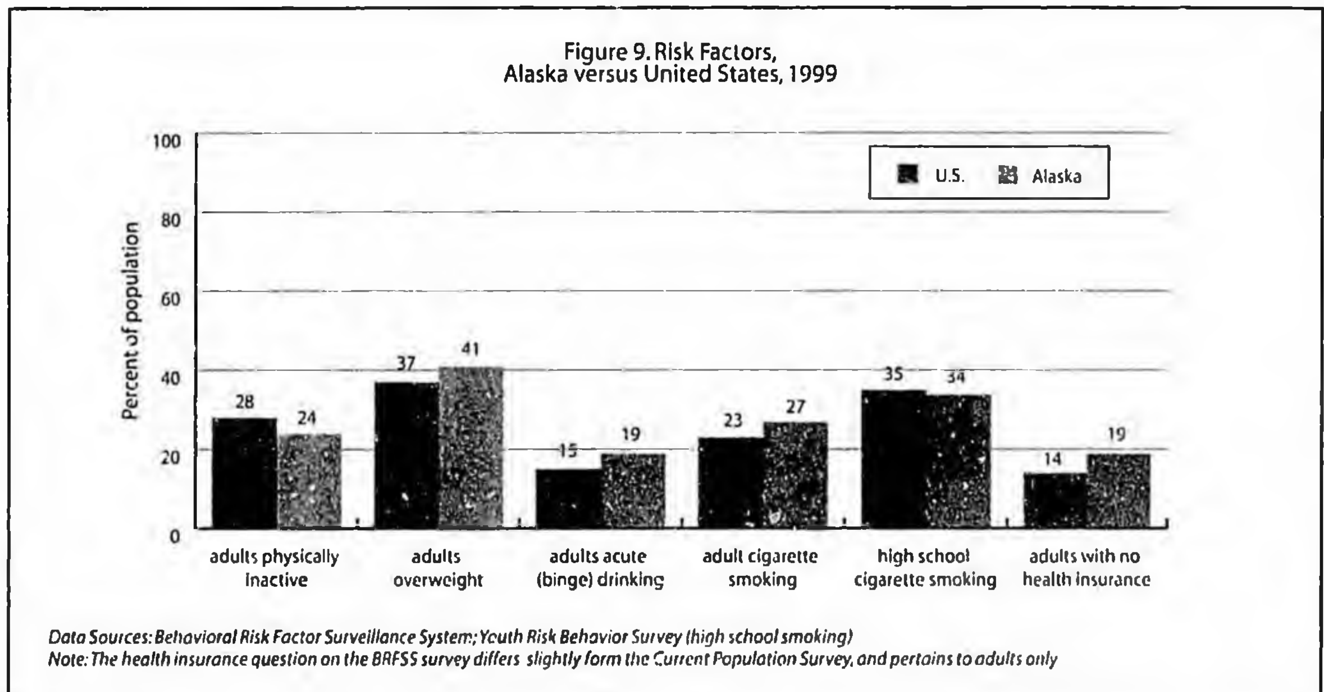


Figure 9. Risk Factors, Alaska versus United States, 1999

Data Sources: Behavioral Risk Factor Surveillance System; Youth Risk Behavior Survey (high school smoking)
Note: The health insurance question on the BRFSS survey differs slightly form the Current Population Survey, and pertains to adults only

now. Tobacco and alcohol use are the most important risk factors for premature death and disease in the U.S. Alcohol is implicated in nearly half of all deaths caused by motor vehicle crashes and a substantial portion of deaths from fires, drowning, homicide, and suicide. Tobacco is a major risk factor for diseases of the heart and blood vessels, chronic bronchitis and emphysema, and cancers of the lung, larynx, pharynx, oral cavity, esophagus, pancreas, and bladder.

The YRBS investigated behaviors related to the leading causes of mortality, morbidity, and social problems among youth in the United States. Examples of high-risk behaviors include carrying a weapon, physical fighting, suicide attempts, drinking and using drugs, and unprotected sexual intercourse. The survey is conducted in schools around Alaska, first in 1995 and then again in 1999. The percentage of high school students who have smoked cigarettes on one or more of the past 30 days is shown in Figure 8. Alaska high school students have smoking rates similar to those of high school students throughout the U.S.

More detail about all the risk factors can be found in the problem-specific chapters of *Healthy Alaskans 2010*.

Leading Health Indicators

The leading health indicators reflect major public health concerns. They relate not only to leading causes of death, but to causes of illness and physical or mental limitations, and to the protective factors that can help assure that healthy people are living in healthy communities. They are meant to be good indicators of Alaskans "living longer, healthier lives."

The Healthy Alaska Partnership Council approved selection of Alaska's leading health indicators from the national list in *Healthy People 2010*, with additions and substitutions to reflect Alaska's priorities. Sixteen of the 23 specific leading health indicators on the Healthy Alaskans 2010 list are the same as those in the national document; three are substitutes for similar indicators but reflect different data sources, and four have been added because of their importance in Alaska. The added indicators measure:

- unintentional injury deaths
- child maltreatment
- post-neonatal mortality
- community access to safe water and proper sewage disposal.

Following the example of *Healthy People 2010*, Alaska's leading health indicators illuminate individual behaviors, physical and social environmental factors, and important health system issues that affect the health of individuals and communities. See Figure 10 for the focus areas covered.

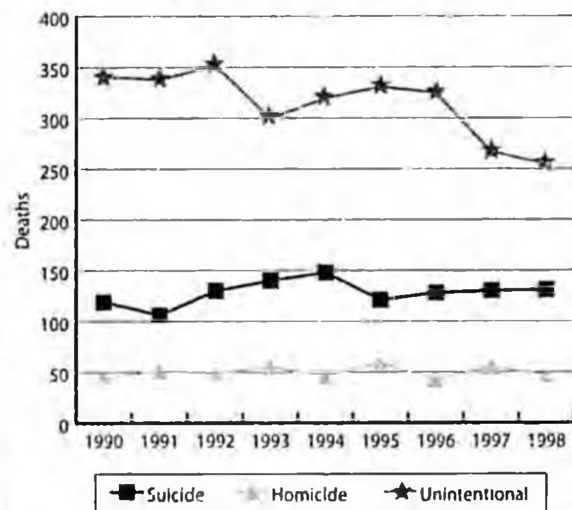
Figure 10. Healthy Alaskans 2010 Leading Health Indicators Focus Areas

- Physical Activity
- Overweight and Obesity
- Tobacco Use
- Substance Abuse
- Mental Health
- Injury Prevention
- Violence Prevention
- Immunization
- Environmental Quality
- Access to Health Care
- Maternal and Child Health
- Responsible Sexual Behavior

Five of the specific leading health indicators count deaths that should be preventable in almost every instance: suicides, homicides, unintentional injuries, motor vehicle deaths (a sub-set of unintentional injury deaths), and post-neonatal deaths (deaths of infants between one month and a year old).

Suicide is a cause for great concern in the state, as Alaska's rate is about twice that for the U.S. population as a whole, and as the rate for Alaska Natives increased over the past decade, reaching a level three times the national rate. The drop in the number and rate in 1999 holds hope for a turnaround after increases earlier in the decade. In the chapters on mental health and substance abuse, contributing causes and related measures of indicators, such as suicide attempts, are discussed in greater detail.

Figure 11. Alaska Deaths due to Unintentional Injuries, Suicides and Homicides by Year, 1990-1998



Data Source: Alaska Bureau of Vital Statistics

Unintentional injury deaths have been decreasing in number. However, the unintentional injury mortality rate for Alaska Natives (119.9 per 100,000) is still twice as high as the rate for all Alaskans (56.1 per 100,000), and more than three times the U.S. rate (35.7). Tracking the overall indicator, its cause-specific components, and related Trauma Registry data will help inform policies and programs aimed at reducing injury incidence and reducing injury deaths.

The targets for 2010 are to reduce by half the rates of homicide deaths and motor vehicle injury deaths, even though these are not areas where Alaska ranks among

the states with the greatest problem. For both, the rates for Alaska Natives are high (see Table 8, Leading Health Indicators). These are priority areas for reducing premature death and for reducing disparities.

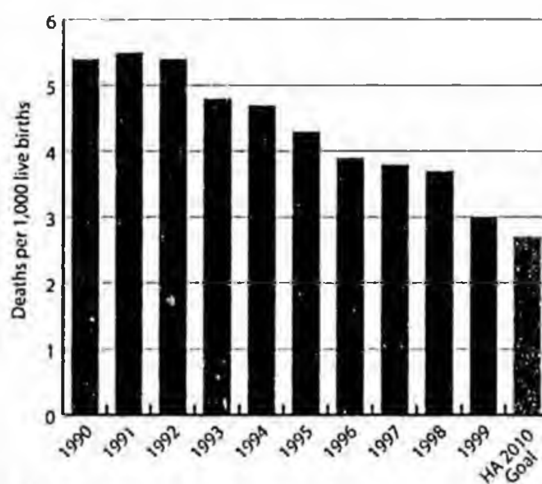
Post-neonatal mortality rate (deaths of infants between 28 days old and one year per 1000 live births) is a more sensitive indicator of well-being of infants than the overall infant mortality rate. The neonatal mortality rate (deaths in the first 28 days of life per 1000 live births), reflecting the health of the mother and the adequacy of the health services provided, is now very low in Alaska – a public health and health care delivery success story. Post-neonatal deaths usually occur because of problems with care or with the environment.

Alaska's overall infant mortality rate is below the U.S. average, yet the post-neonatal mortality rate has remained higher than the U.S. rate (2.4 in 1998), and should be amenable to dramatic improvement. "Sudden infant death syndrome (SIDS)" and "injuries" (suffocation, drowning, fire and motor vehicle injuries) account for most of the post-neonatal deaths. The SIDS rate in Alaska is over twice the U.S. SIDS rate. Alaska Natives have over twice the risk of infant death due to SIDS and other asphyxia as Whites. A reduction in SIDS deaths, particularly among Alaska Natives, would make a large contribution toward reducing the post neonatal mortality rate for Alaska.

Communities across Alaska have been working to change expectations and behavior that may have major impact on many of the leading health indicators and result in better health status, including longer and healthier lives. Local initiatives and statewide efforts early in the decade include "Trampling Tobacco (ANHB)," "Take Heart Alaska" (statewide coalition to reduce heart disease by educating people about good diet and physical activity benefits), "Eat Smart," "Five-a-Day" to encourage more vegetables and fruits in the diet, "Walk your child to school" days, worksite wellness resources development, "Stop the Pop (ANTHC and Native Health Corporations)," "Breath Free (YKHC)," the Alaska health fairs, and others.

Illness, disability and early deaths from heart disease and cancer will decrease if people are more physically active, eat better and smoke less. Less alcohol use could help reduce unintentional and intentional injuries, infant deaths and child maltreatment, and could either reflect or facilitate improved mental health of the population. It is hoped that measuring progress or problems with the leading health indicators will provide warnings about how the state is doing with respect to the goal of Alaskans living longer and healthier lives. If progress is made on all these indicators over the decade, premature deaths should be reduced, as well as the burden of illness and disability in the state.

Figure 12. Post-Neonatal Mortality Rates in Alaska 1990-1999



Data Source: Alaska Bureau of Vital Statistics

In summary, the leading health indicators are related to underlying social, economic and environmental conditions. Many of the underlying conditions, including income and education levels, health-related lifestyle habits, and water and air quality are likely to have improved as well if the leading health indicators improve. Indeed, the indicators were selected partly on the basis of their sensitivity to changes in known contributing causes.

The detailed focus area chapters in *Healthy Alaskans 2010 Volume I: Targets for Improved Health* contain dozens of additional indicators of health status, outcomes, risk factors and protective factors, as well as measures of access to care and services, and availability and capacity of health care and public health systems. These more specific and detailed indicators and targets relate to policies and programs for each of the areas of concern.

Table 8

Healthy Alaskans 2010 Leading Health Indicators

	Indicator	Alaska Data Source	US Baseline	Alaska Baseline	Alaska Target Year 2010
	Physical Activity				
1	Increase the proportion of adolescents who engage in vigorous physical activity (percent of high school students grades 9-12 who exercise or participate in sports activities for at least 20 minutes that cause sweating and heavy breathing on 3 or more of the past 7 days)	YRBS	65% (1999)	72% (1999) 59% (AK Native 1999)	85%
2	Increase the proportion of adults who engage in regular, preferably daily, moderate physical activity (percent of people aged 18 years and older who engage in physical activity five or more sessions per week for 30 or more minutes per session, regardless of intensity)	BRFSS	20% (1998)	25% (1998) 17% (AK Native 1998)	40%
	Overweight and Obesity				
3	Reduce the proportion of adolescents who are overweight (percent of high school students grades 9-12 with body mass index greater than or equal to the 95th percentile, based on age-sex specific NHANES 1)	YRBS	10% (1999)	7 % (1999) 9% (AK Native 1999)	5%
4	Reduce the proportion of adults who are obese (percent of persons aged 18 years and older with body mass index greater than or equal to 30kg/m²)	BRFSS	20% (1999)	20% (1999) 30% (AK Native 1999)	18%
	Tobacco Use				
5	Reduce cigarette smoking by adolescents (percent of high school students grade 9-12 wh[illegible]ve smoked cigarettes on one or more of the past 30 days)	YRBS	35% (1999)	34% (1999) 55% (AK Native 1999)	17%
6	Reduce cigarette smoking by adults (percent of adults aged 18 years and older who smoked more than 100 cigarettes in their lifetime and smoked on some or all days in the past month)	BRFSS	23% (1999)	27% (1999) 42% (AK Native 1999)	14%
	Substance Abuse				
7	Increase the proportion of adolescents not using alcohol or illicit drugs during the past 30 days (percent of high school students grades 9-12 who have not used alcohol, marijuana, or cocaine in past 30 days)	YRBS	46% (1999)	49% (1999)	60%
8	Reduce binge drinking among adults (percent of persons aged 18 years or older who consumed five or more drinks on one occasion within the p[illegible] 30 day period)	BRFSS	15% (1999)	16% (1999) 27% (AK Native 1999)	13%
	Mental Health				
9	Reduce the suicide rate (deaths per 100,000 population)	ABVS	10.6 (1999)	17.2 (1999) 32.6 (AK Native 1999)	10.6
	Injury Prevention				
10	Reduce deaths caused by unintentional injury (deaths per 100,000 population)	ABVS	35.7 (1999)	56.1 (1999) 119.9 (AK Native 1999)	31.4
11	Reduce deaths caused by motor vehicle crashes (deaths per 100,000 population)	ABVS	15.5 (1999)	14.7 (1999) 27.6 (AK Native 1999)	7.0
	Violence Prevention				
12	Reduce deaths from homicides (deaths per 100,000 population)	ABVS	6.1 (1999)	8.1 (1999) 29.4 (AK Native 1999)	4.0
13	Reduce child maltreatment (rate of substantiated reports of child maltreatment per 1,000)	DHSS/DPH, DFYS; state fiscal years	11.8 (1999)	16.5 (1995-1999)	10.0

Healthy Alaskans 2010 Leading Health Indicators

	Indicator	Alaska Data Source	US Baseline	Alaska Baseline	Alaska Target Year 2010
	Immunization				
14	Increase the proportion of young children who have received all vaccines recommended for universal administration (percent of children aged 19 to 35 months who have received recommended doses of DTaP, polio, MMR, Hib, and Hep B vaccines, the 4:3:1:3:3 series)	National Immunization Survey	73% (2000)	71% (2000)	90%
15	Increase the proportion of elderly adults immunized against influenza and pneumococcal disease (percent of adults aged 65 years and older who have received an influenza vaccine in the past year; percent of adults aged 65 and older who have ever received a pneumococcal vaccine)	DHSS/DPH, Epidemiology	64% (influenza) 46%(pneumococcal) (1998)	60 %(influenza) 60% (AK Native) 43% (pneumococcal) 53% (AK Native) (1999)	90% (influenza) 90% (pneumococcal)
	Environmental Quality				
16	Increase communities with access to safe water and proper sewage disposal	DEC		88% (2000)	98%
17	Reduce the proportion of nonsmokers exposed to environmental tobacco smoke	BRFSS	65% of non-smokers (1988-1994 NHANES)	Developmental	
	Access to Health Care				
18	Decrease the percent of Alaskans without health insurance coverage throughout the year	CPS	14.0%(2000)	19.3%(2000)	5%
19	Increase the proportion of adults aged 18 or older with a usual place to go for care if sick or needing advice about health	BRFSS	84% (1997) NHIS	79.3% (1997)	100%
	Maternal and Child Health				
20	Increase the proportion of pregnant women receiving adequate prenatal care (percent of live births with APNCU Index greater than or equal to 80)	ABVS	75% (1999)	67.1% (1999) 47.2% (AK Native 1999)	90%
21	Reduce postneonatal death rate (deaths between 28 days and 1 year per 1,000 live births)	ABVS	2.3 (1999)	3.0 (1999) 6.1 (AK Native 1999)	2.7
	Responsible Sexual Behavior				
22a	Increase the proportion of adolescents who abstain from sexual intercourse (percent of high school students grades 9-12 who have never had sexual intercourse)[1]	YRBS	50% (1999)	57% (1999) 46% (AK Native 1999)	65%
22b	Increase the proportion of sexually active adolescents who use condoms (percent of high school students grade 9-12 who had intercourse in past 30 days who used condom at last intercourse)	YRBS	58% (1999)	56%(1999)	75%
23	Increase the proportion of sexually active persons who reported condom use at last intercourse (percent of sexually active unmarried women (divorced, widowed, separated, never married, or member of an unmarried couple) aged 18-44 years who reported condom use at last intercourse. The comparable proportion for Alaska males was 45%)	BRFSS	23% (1995)	33% (1997)	50%

[1]The National Leading Health Indicator combines 22a and 22b.
YRBS - Alaska Youth Risk Behavior Survey. Alaska sample for 1999 did not include Anchorage. High school data for 1999 are weighted and representative of the state student population excluding Anchorage.
BRFSS - Alaska Behavioral Risk Factor Surveillance System. All US BRFSS data are age-adjusted to the 2000 population; the Alaska BRFSS data have not been age adjusted, so direct comparisons are not advised. See Technical Notes
NHANES - National Health and Nutrition Evaluation Survey
ABVS - Alaska Bureau of Vital Statistics, All mortality rates age-adjusted to US 2000 standard population
DHSS/DPH Alaska Department of Health and Social Services/Alaska Division of Public Health
DFYS - Division of Family and Youth Services
DEC - Alaska Department of Environmental Conservation
CPS - Current Population Survey, U.S. Bureau of the Census
APNCU - Adequacy of Prenatal Care Utilization Index, See Appendix Technical Notes

The Challenge to Eliminate Health Disparities

The national *Healthy People 2010* sets as a goal the elimination of health disparities. These are defined as "differences in health status that occur by gender, race or ethnicity, education or income, disability, living in rural localities or sexual orientation."[1] Although some differences in health status between groups are biologically determined (such as cervical cancer and prostate cancer) other differences are related to more complex interactions of biology and behavior. For example, men (in Alaska and in the U.S. as a whole) are more likely to die of heart disease, suicide and injuries than are women.[2] However, women are more likely to attempt suicide and are at greater risk for depression and Alzheimer's disease.[3,4]

The most dramatic and pervasive group differences in health status in Alaska are those between Alaska Natives and the majority white population of the state. Public health efforts over decades have led to dramatic improvement in the health status of Alaska Natives in the areas of infant mortality, injuries, and infectious disease, but disparities persist, and appear to be increasing in some areas (notably suicide and homicide rates).

Healthy Alaskans 2010 has set a single target for every health status indicator for all racial and ethnic groups, with the intention of developing strategies to improve health status for all, and to focus on reduction of the disparities by promoting health and preventing disease and by ensuring access to appropriate care. Efforts are planned to track progress for all groups for whom it is feasible to measure such progress over the decade. Comparisons will be made between specific racial and ethnic groups and between males and females where this is informative about risk factors, effectiveness of programs, or need for services.[5]

Race and Ethnicity

Differences in socioeconomic status account for much, but not all, of the observed variation in health status among racial and ethnic groups. The fact that racial groups typically differ by socioeconomic status reflects one aspect of the profound effect race may have on a person's life. Many authors have pointed out that race represents more of a cultural grouping than a biologic one.[6,7,8,9] However, monitoring health disparities by race is important for several reasons. Historically, racial categories have been used as proxies for socioeconomic characteristics. As an important social category, racial distinctions have consequences for many aspects of life. Biological differences, to a large extent, do not exist between racial groups. The variation in health status by race and ethnicity reflects complex interactions of biological, cultural, socioeconomic, political and legal factors, as well as racism.[10]

Measuring health status in minority populations can be difficult because of small populations, inaccurate denominators and misclassification of racial status.[11,12] Small populations in Alaska pose the largest difficulty in ascertaining health status for African-Americans, Asian/Pacific Islanders and persons of Hispanic origin. Several years of data are usually needed to obtain enough events to validly measure health status. Annual trends are extremely difficult to document. Commonly data in Alaska is stratified by Alaska Native/Non-Native, which may obscure other racial and ethnic disparities. Finally, the changes in the definitions of race in the 2000 census will further complicate the monitoring of health status by race and ethnicity.

As noted, Alaska Natives comprise the largest minority population in Alaska. The majority reside in over 200 largely remote and rural communities delineated as Alaska Native Villages; only 39% live in the six largest census areas. The median age of the Alaska Native population, 23.3 years in 2000, is younger than that for the overall Alaska population. The life expectancy at birth for Alaska Natives is 69.4 years, compared to 75.7 for whites.[13] Although a great deal of progress was made during the 1990s to decrease health disparities between Alaska Natives and non-Natives (for example, infant mortality decreased, injury mortality decreased, and homicide mortality decreased), significant disparities persist.[14]

In 2000, 25,547 African-Americans resided in Alaska. The vast majority (92%) of African-Americans live in either Anchorage or Fairbanks. The median age of the African-American population in Alaska is 27.0, lower than the white median age of 35.4. In general, the health status of Alaska's African-American population tends to be similar to or better than that of the overall state, possibly because of the young age of the population. However, disparities exist. For example, African-Americans have twice the infant mortality rate of whites, and the highest race-specific rates of low birth weight, very low birth weight and pre-term birth.

About two thirds of Asians, Native Hawaiians and Pacific Islanders reside in either Anchorage or Fairbanks. There are also sizable Asian, Native Hawaiian and Pa-

cific Islander populations in non-urban Alaska; nearly 3000 resided on Kodiak Island and another approximately 3000 resided in the Southwest region in 2000. The median age was 34.5 for the Asian group in 2000, and 22.4 for Native Hawaiians and Pacific Islanders. The Asian/Pacific Islander population grew by 73% from 1990 to 2000, compared to an overall population growth of 14%. For many health status indicators, persons of Asian/Pacific Islander descent appear to have better health status than the overall population (one exception is tuberculosis incidence).[15] However, studies need to be done to validate these findings, especially in view of the rapid increase in that population.

As reported in the 2000 census, 25,852 persons of Hispanic origin live in Alaska. Of these, 71% live in Anchorage or Fairbanks. There are also sizable Hispanic populations in non-urban Alaska; 848 live on Kodiak Island and 1214 in the Southwest region. The median age of the Hispanic population in 2000 was 23.8 years. The Hispanic population increased by about 45% between 1990 and 2000. Because of the rapidly changing population, and the difficulty in ensuring reliable recording of Hispanic ethnicity on birth and death certificates and in surveys consistent with the self-reports on the decennial census forms, it has been difficult to obtain accurate information for many health status indicators.

Socioeconomic Status

Socioeconomic status has a profound influence on health. Differences in health status by socioeconomic status have been documented for centuries. Nonetheless, we do not have a clear idea about how and why health status is so profoundly affected by socioeconomic status.[16] Many different indicators have been used to measure socioeconomic status, including income, educational status and occupation. Recent research has found that the degree of discrepancy in health status by income is directly correlated with the degree of income disparity in the society. In other words, it is not the degree of income, but one's relative income within the society.[17] Research in the U.S. has found that social cohesion is inversely correlated with mortality rates.[18]

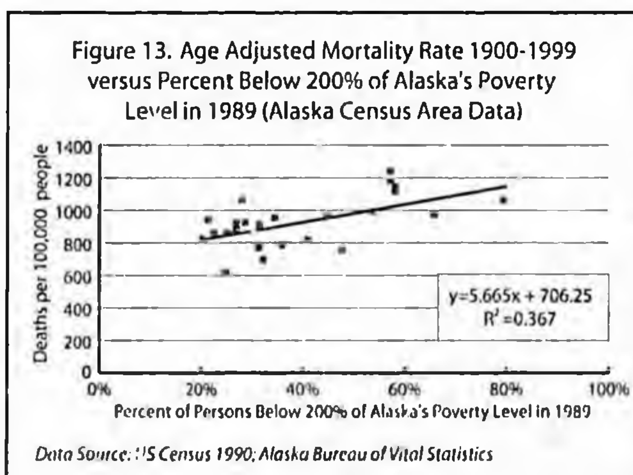


Figure 13. Age Adjusted Mortality Rate 1900-1999 versus Percent Below 200% of Alaska's Poverty Level in 1989 (Alaska Census Area Data)

Data Source: US Census 1990; Alaska Bureau of Vital Statistics

In Alaska, the overall mortality rates in each census area are directly correlated to the percent of individuals in each census area who were living below the federal poverty level in 1990 (Figure 13).

Another example of the dramatic effect of socioeconomic status on health is the relationship between educational attainment and current smoking. Among college graduates in Alaska, only 12% are current smokers, but among those with less than a high school education, 47% currently smoke.[19]

Geographic Location

Monitoring health status by geographic location is important because it provides local information and identifies issues that may be most pertinent for that region. For example, rates of unintentional injury morbidity and mortality are much higher in rural Alaska.[20] However, for small communities or even large areas with relatively small populations, presentation of health status information is complicated by the fact that presence or absence of uncommon events can cause sudden jumps or drops in disease or death rates that are not very informative about the health of the community. Survey-based data on health risks is informative about regional differences (for example, in smoking prevalence, prevalence of overweight, and access to primary care services). Over the decade, such surveys will be very informative to citizens, community-planners and state policy-makers.

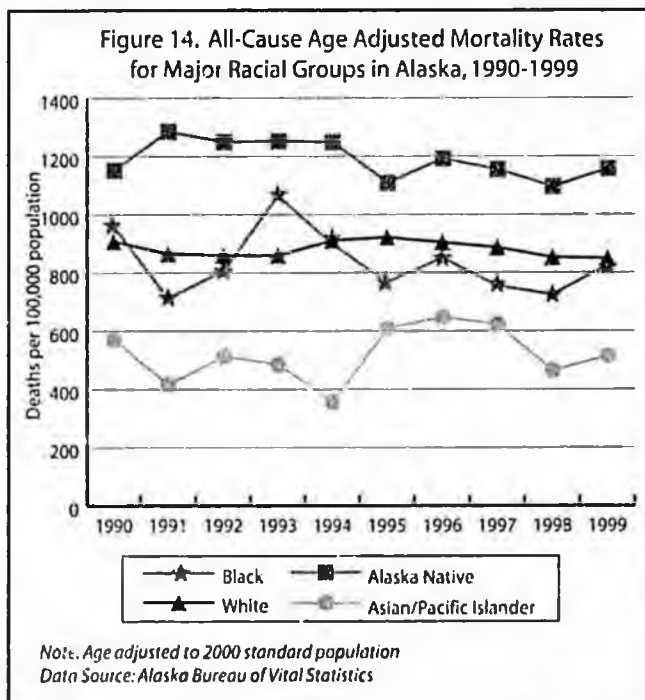
Another important issue for Alaska is the difficulty of providing health care to rural areas. Residents in rural Alaska face challenges in obtaining access to quality health care. Nearly one-fourth of the state's population lives in areas accessible only by boat or aircraft. Transportation to and from hospitals and clinics is expensive, and sometimes even impossible because of poor weather. In addition, rural areas often lack qualified health professionals. Rural residents often lack access to other services that promote good health, such as facilities for obtaining regular exercise, healthful foods in the grocery stores and smoking cessation programs.

Disability

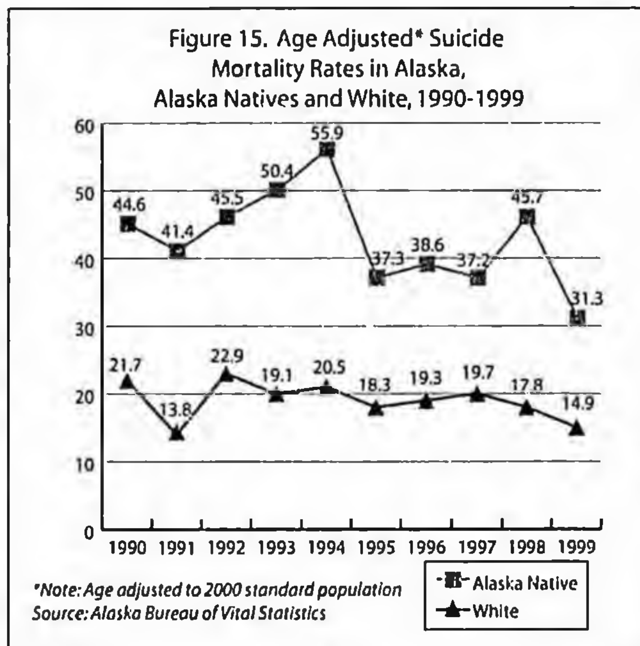
Alaska does not currently have a systematic approach to monitoring health status among individuals with disability. *Healthy Alaskans 2010* identifies several data indicators that the state hopes to be able to monitor by the end of the decade.

Selected Measures of Disparities in Health Status and in Risks

Major health status disparities between racial groups that are reflected in mortality and reportable diseases include notably unintentional injuries, suicide and homicide. Vital statistics indicate that in Alaska, mortality rates for African Americans and for Asians and Pacific Islanders are lower than for the White population, but overall mortality rates for Alaska Natives are persistently higher than those for all other racial groups.



Suicide has accounted for about 130 deaths of Alaskans each year of the past decade. Suicide rates are highest among Alaska Natives (31.3 per 100,000 in 1999 as shown in Figure 15), with rates that are more than twice as high as the rate for Whites (14.9 in 1999) throughout the time period. Lower rates for both Alaska Native and White racial groups in 1999 offer hope of a downward trend for both groups. To reach the target of 10.6 for 2010 (which is the 1999 Unites States suicide mortality rate), Alaska Native



suicides annually will be only one fourth of the current number – fewer than twelve per year rather than the recent average of 43 per year.

For both unintentional injuries and intentional injuries (suicide and homicide) the disparities in mortality rates persist between Alaska Natives and other racial groups of the population. At least for unintentional injuries the rates have been dropping quite steadily, and for Alaska Native these rates have improved more dramatically than for the population as a whole. The most common causes of injury deaths in Alaska, including both unintentional and intentional (homicide and suicide) are firearms (26%), motor vehicles (17%), drowning (12%), poisoning (5%), strangulation (5%) and fire/burns (4%).

The successes of prevention programs like "Kids Don't Float" and boater safety education, and worker safety efforts that have reduced work-related deaths, exemplify the potential for bringing injury deaths down. Improved access to mental health services at the community level, and opportunities for success for youth and people of all ages, may help to reduce the risks and risky behaviors that lead to disabling and fatal injuries.

Several isolated but serious outbreaks of new Tuberculosis cases in the last decade affected Native communities and the Asian and Pacific Islander population. In 1998, the incidence rate resulting from an outbreak among Asian and Pacific Islanders was 38 cases per 100,000.

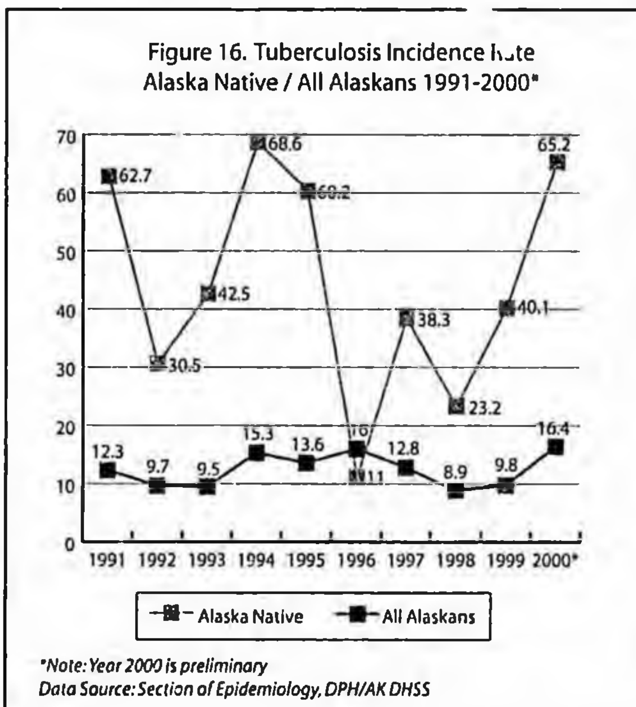


Figure 16. Tuberculosis Incidence Rate Alaska Native / All Alaskans 1991-2000*

*Note: Year 2000 is preliminary
Data Source: Section of Epidemiology, DPH/AK DHSS

Summary

Data on risks and health status suggests that the largest disparities are between Alaska Natives and the other racial groups. Differences between men and women are of concern where lifestyle or exposure to environmental risks differ, or where insurance coverage or access to care differs.

Age related risks (for example, for children, adolescents, elderly) need attention particularly in the organization of services. Having emergency medical equipment that is suitable for the care of small children, and having home and community based services that allow elders and people with special needs to remain in their communities are assets that contribute to community wellness. More complete data systems may, over the decade, be able to inform people better at the community and state level about risk and protective factors, about non-fatal outcomes like emergency calls and hospitalizations, and about services available and likely to be needed in the future.
Alaska made progress during the 1990s in limited areas to reduce health disparities. *Healthy Alaskans 2010* will support work over the decade to monitor disparities in both health status and in access to services, and to evaluate the efforts of community, state and national organizations to eliminate them.

Endnotes

[1] U.S. Department of Health and Social Services. Healthy People 2010 (Conference Edition, in two volumes). Washington DC;2000. page 11-16.
[2] Alaska Bureau of Vital Statistics. 1998 Annual report.
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[5] We avoid making contrasts such as Alaska Native to "Non-Native" but instead use the comparison to All Alaskans or to a specific group for comparison such as white or Asian and Pacific Islander.
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[20] See annual Alaska vital statistics reports and *Health Status in Alaska: 2000 Edition.*

Highlights of Health Topics Chapters

Healthy Alaskans 2010 Volume I: Targets for Improved Health

- *Health Promotion*
- *Health Protection*
- *Preventive Services and Access to Care*
- *Public Health Infrastructure*

Highlights of Health Topics Chapters

Health Promotion

Health promotion includes health education and the fostering of healthy individual behavior and healthy lifestyles. Improving knowledge and understanding of hygiene, nutrition, exercise, human life cycle and aging, proper food handling, the effects of dangerous substances like alcohol, tobacco smoke and inhalants, and the risks of contaminants in water, air or food, are all part of health promotion. School curricula and instruction for new parents and for caregivers for people of all ages can assist in promoting good health, as can public media and community programs, both formal and informal. Educational and community-based programs and health communication can change behavior to improve health. Lessons learned over decades of effort to improve the effectiveness of health education suggest that individuals need knowledge, means and motivation to change behavior.

Health promotion materials provided by health care providers, public health agencies or voluntary programs usually aim to help people individually or at a community level identify needs and health priorities, obtain resources and information, and take action in their households, schools, places of work, and communities. The chapters of *Healthy Alaskans Volume I: Targets for Improved Health* in the Health Promotion cluster specify opportunities for measurable improvements in wellness and healthy, longer lives for Alaskans. These chapters spell out targets for reaching the general population and groups at special risk with information and services, and for achieving measurable change in individual behavior and related health outcomes.

1. Physical Activity and Fitness

Goal: Improve health, fitness, and quality of life through daily physical activity.

In Alaska over 50% of the population exercises on an irregular basis, or not at all.

Adolescents in Alaska report more vigorous physical activity than their peers throughout the U.S., as well as more time being active in their school physical education classes. However, a lower percentage of students report daily participation in their physical education classes in Alaska than in the U.S.

The State of Alaska spends more funds per capita on bicycle and pedestrian facilities (sidewalks, urban trails, bike lanes) than other states, primarily through its Trails and Recreational Areas in Alaska (TRAAK) grants. Trails serve multiple purposes and now are seen as an asset for individuals, communities, and tourism.

2. Nutrition and Overweight

Goal: Promote health and reduce chronic disease associated with diet and weight.

Diet and nutrition play an important role in the development or prevention of four of the top ten leading causes of death in Alaska and the U.S.: cancer, coronary heart disease (CHD), stroke, and type 2 diabetes.

Overweight and obesity affect a large proportion of the Alaska population. According to Alaska Behavior Risk Factor Surveillance Survey (BRFSS) data over the last decade, the percent of overweight adults (body mass index greater than 25 and less than 30) age 18 and older has increased from 35% in 1991 to 40% in 1999. Obesity (body mass index greater than 30) increased from 13% to 20% in the same interval.

Several state programs aim to provide better nutrition for selected populations, for example, promotion of breastfeeding to maintain Alaska's current high rates; the Alaska WIC Program, an effort to improve nutrition among pregnant and new mothers and their infants; and the Alaska Food Stamp Program which helps low-income families maintain adequate nutrition by providing economic supports.

3. Tobacco Use

Goal: Reduce illness, disability, and death related to tobacco use and exposure to secondhand smoke.

More than one out of four Alaskans are addicted to tobacco. Nearly one-half of these people will die prematurely as a result of their addiction. Non-smokers, including many children, are exposed to the hazards of secondary smoke.

Alaska has one of the highest smoking rates in the United States, similar to the rates of the tobacco growing states. Alaska Natives have smoking rates almost double those of other Alaskans. Smokeless tobacco use is also common in Alaska.

Since passage of a $0.71 per pack cigarette tax increase in 1997, there has been a 16% decrease in taxable cigarette consumption, which has persisted for three years. Sales of other tobacco products have also declined and

tax revenue to the state from the sale of cigarettes and other tobacco products has tripled.

4. Substance Abuse

Goal: Reduce substance abuse to protect the health, safety, and quality of life for all, especially children.

Alcohol is the Alaskan's drug of choice. The Alaska Division of Alcoholism and Drug Abuse estimates that 14% of the Alaska population abuses alcohol or is dependent on alcohol, compared to 7% of the U.S. population. The social cost of alcohol abuse is seen in rates of related injuries, chronic disease, and deaths. Substance abuse is implicated in more than 75% of all cases of child abuse and neglect and in more than 80% of all adult crimes. According to data gathered between 1991-93, compared with other states, Alaska ranked first in the number of deaths with alcohol involvement and second in the percentage of chronic drinkers. Alaska ranks highest in the rate of Fetal Alcohol Syndrome, a entirely preventable birth defect.

Inhalant abuse by children and adolescents is a serious health and social issue in Alaska. The first treatment facility for inhalant abuse opened in Bethel in 2001.

Environmental strategies can limit consumption of alcohol. For example, when communities regulate the importation, possession and sale of alcoholic beverages under the local option provision of Alaska law, they have reduced the prevalence of binge drinking and reduced injuries (particularly vehicle injury, homicide, and hypothermia). Increases in taxation levels are a strategy to reduce alcohol consumption by youth. Coordinated prevention efforts can also have marked impacts on drug and alcohol use rates among adolescents.

5. Mental Health

Goal: Improve mental health and ensure access to appropriate, quality mental health services.

The population with mental illness in Alaska is estimated using a national formula which counts only individuals whose mental illness causes significant functional impairments in daily living. Estimates project about 10% of Alaska's children age 5 to18 have severe emotional disturbances, and 6.2% of Alaska's adult population under age 55 suffer from severe mental illness. Only a small proportion of these individuals receive mental health treatment.

Alaskans commit suicide at a greater rate than Americans as a whole. Suicide is a symptom of major depressive disorders and is more common among people with co-occurring mental health and substance abuse disorders. The suicide mortality rate, which is twice the national rate, has not declined during the 1990s. Rates are highest among young men and among Alaska Natives. Between 1990 and 1998, more than 180 Alaskan communities were impacted by suicide, leaving families, friends and communities suffering from the trauma. Suicide attempts, like completed suicides, reflect the poor mental health of individuals and communities.

The Community Based Suicide Prevention Program, a nationally recognized prevention effort, was initiated in 1988. It issues grants to small community projects to reduce self-destructive behavior and suicide and to increase individual and community wellness.

Limited access to treatment is a major mental health care issue. In rural Alaska at least 175 villages have no local mental health services other than the occasional itinerant provider and many other communities have only part-time workers helping with mental health needs.

6. Education and Community Based Programs

Goal: Increase the quality, availability, and effectiveness of educational and community-based programs designed to prevent disease and improve health and quality of life.

School health programs can include on-site health services, school nurses and counselors, and peer education or mentorship programs, all of which support students' health and well-being. Only 10 of Alaska's 56 school districts employ school-based nurses, and only one Alaskan school includes an on-site health clinic. The Alaska Department of Education and Early Development has developed content standards for health education entitled *Skills for a Healthy Life*. The Anchorage School District participates in the Coordinated School Health Programs. Its philosophy is that integrated efforts of schools, families, health professionals, and community agencies have "complementary if not synergistic effects" in protecting and improving the well-being of children and youth.

The Alaska Native Tribal Health Consortium's 2000-2005 Strategic Plan includes the goal of increasing emphasis on health promotion and disease prevention. The approach emphasizes traditional Native healing and Native approaches to supporting community and individual wellness.

The Division of Public Health was awarded a national public health improvement planning grant (Robert Wood Johnson Foundation) that was paralleled by three local public health improvement planning grants across the state ("Turning Point" community grants funded by the Kellogg Foundation). This process resulted in a statewide health assessment, assessment of the public health system in Alaska, and prioritized strategies for public health in the 21st century in Alaska. This effort led to the development of the Healthy Alaskans 2010 planning process. Local grantees, while participating in the state process, also worked on priority public health needs in their communities. These projects currently are ongoing in Kenai, Sitka, and Fairbanks. Information on the Turning Point communities is available at www.hss.state.ak.us/dph/APHIP/HOME.HTM.

The Youth Developmental Assets framework, a strengths-based model for working with youth, focuses on increasing protective factors for children and youth. In Alaska, a partnership initiative between the Association of Alaska School Boards and the Department of Health and Social Services has promoted the Assets approach through educational workshops, conferences and technical assistance statewide. In 1998 the book, *Helping Kids Succeed ~ Alaskan Style* was published based on the 3000 asset ideas contributed from Alaskans across the state.

7. Health Communication

Goal: Use communication strategically to improve and protect health.

Health communication is the art and technique of informing, influencing, and motivating individual, institutional, and public audiences about important health issues.

Public education campaigns in Alaska include nutrition and physical activity messages contained in the *5 a Day for Better Health* (and 5 a Day the Alaskan Way) and the *30 Active Minutes Every Day.* The Alaska Native Tribal Health Consortium's *Stop the Pop* campaign focuses on the contribution of highly sugared soft drinks to dental caries, obesity, and diabetes, and *Inform and Inspire 2000* promoted personal health and wellness for Alaska Natives.

Health care provider organizations, the telecommunications industry, and the Alaska Telehealth Advisory Council are working to improve telecommunications infrastructure for the health care system and for the general population.

The Division of Public Health participates in the *Consumer Health Information Advisory Committee* of the National Network of Libraries of Medicine, Pacific Northwest Region, an effort to reach minorities, senior citizens and low income families to improve their access to electronic consumer health information.

Health Protection

Health protection refers to the activities that assure the safety of food, water, air, drugs and appliances. Making sure that clinics, hospital laboratories, and blood banks are reliable, and that health care professionals are qualified to serve, are shared responsibilities between state and local governments and professional organizations.

Setting standards, adopting regulations and implementing and enforcing them may happen at the local, state or federal level depending on the scope of authority to deal with the specific issue, the nature of the problem, and the level of consensus. For example, in some states, helmet laws for children riding bicycles have been adopted at the state level, while in other states, individual communities have adopted local regulations. Some immunization regulations and disease reporting requirements are national, while others are state-specific.

Environmental and public health agencies share responsibility for safety of schools and restaurants, water supplies, and waste disposal. In Alaska they share the implementation of tobacco control enforcement. Injury prevention and child abuse prevention efforts are shared among a variety of governmental, non-profit and other organizations. For some problems, like designating land or funds for neighborhood exercise trails, or starting a recycling program to reduce waste, community action can muster resources or provide the forum for change. Communities can set standards or organize needed services (including public clinics or coordinated emergency services), in instances where individuals on their own cannot solve the problem.

8. Injury Prevention

Goal: Reduce injuries, disabilities, and deaths due to unintentional injuries.

Alaska has the highest injury rates in the nation. Both the intrinsic hazards of the Alaska environment and low rates of protective behavior contribute to injuries and injury deaths.

Unintentional injury death rates in Alaska declined 36% from 1989 to 1999, but when age-adjusted were still 57% higher than the U.S. rate in 1999. Firearm death rates in Alaska are almost twice the national rate, and for Alaska Natives more than four times the national rate. Residential fire death rates in Alaska are three times the national rate. The drowning rate in Alaska is over five times the national rate.

The Alaska Injury Prevention Center is a statewide, non-profit corporation which develops plans for prevention of home and leisure injuries, workplace injuries, and intentional injuries. Elders' safety and children's safety plans will also be developed.

The Alaska Native Tribal Health Consortium (ANTHC) identified injury prevention as a priority area in its 2000-2005 Strategic Plan. ANTHC participates in the national Indian Health Service Injury Control Initiative, the Alaska Boating Safety Advisory Council, and the Alaska Injury Prevention Center. ANTHC's Department of Environmental Health and Engineering advises tribal health organizations on the development of injury prevention programs.

9. Violence and Abuse Prevention

Goal: Reduce injuries, disabilities, and deaths due to violence.

Between 1995 and 1997, the Alaska violent crime index decreased 15%. However, Alaska's rates for all violent crimes except robbery exceed the national average. In 1998, Alaska had the highest rate among 50 states for forcible rape, and its rates of aggravated assault and murder were 9th and 19th highest, respectively.

Seventy percent of Alaskan homicide victims are male. Alaska Natives are more likely than other Alaskans to be victims, accounting for 31% of homicide deaths, though they are only 18% of the population.

There were more than 17,500 incidents of domestic violence serious enough to require refuge in one of Alaska's domestic violence shelters in fiscal year 2000. A new data system developed in 2001 by the Council on Domestic Violence and Sexual Assault indicates that between 7,500 and 8,000 Alaskans were victims of domestic violence.

In fiscal year 2000, programs funded through the Council served 9,862 clients who were victims of domestic violence and 1,301 clients who had experienced sexual assault. The Council is an administrative, policy-making unit of the Department of Public Safety. The Alaska Network on Domestic Violence and Sexual Assault is a statewide coalition of 21 domestic violence and sexual assault programs.

The Alaska Family Violence Prevention Project, part of the Section of Maternal, Child, and Family Health, has developed and delivered training to hundreds of health and social service professionals throughout the state, provides technical assistance for policy development, and maintains a clearinghouse of resource and training materials.

The Anchorage Social Services Division's SAFE City Program develops community prevention and intervention programs for domestic violence, child abuse, and sexual assault.

10. Occupational Safety and Health

Goal: Reduce the number of work-related injuries and deaths in Alaska.

Alaska has the highest worker death rate in the nation. In 1998 and 1999, the annual fatality rates for Alaska workers were approximately 3 times the national average rate.

Work related deaths are decreasing in Alaska. Rates declined 55% from 30 per 100,000 workers in 1990 to 13 per 100,000 workers in 1999. The total number of fatalities decreased 49% from 82 in 1990 to 42 in 1999.

A multiple-source traumatic occupational fatality surveillance system was established in 1992 by the Division of Public Health. The Division of Public Health also administers the state-based Fatality Assessment and Control Evaluation program under a cooperative agreement with National Institute for Occupational Safety and Health. The Alaska Department of Labor and Workforce Development maintains a database on occupational injuries.

11. Environmental Health

Goal: To ensure all Alaskans have access to safe water and food and live in healthy communities.

The percentage of rural households with access to running water and sewer systems increased from 56% in 1996 to 69% in 2000.

The Alaska Native Tribal Health Consortium's Department of Environmental Health and Engineering constructs water, wastewater, and solid waste disposal systems in more than 109 Native communities.

The Municipality of Anchorage's Environmental Services Division (within the Department of Health and Human Services) focuses on air and water quality and public facility sanitation. The Customer Service Section, Air Quality Program, I/M Vehicle Inspection Program, and the Environmental Sanitation Program all provide public health education and as well as code enforcement.

The Division of Environmental Health of the Alaska Department of Enviromental Conservation (DEC) developed a community action manual for village environmental issues in partnership with Chugachmiut. *Seven Generations* was published in 1999. The manual helps village residents identify and prioritize environmental issues within their own community.

The Governor's Council on Rural Sanitation was established in 1995 to develop a comprehensive plan for safe water and adequate sewage disposal for rural Alaskans, the *Rural Sanitation 2005 Action Plan.*

Air pollution has been linked to a variety of health problems, including the respiratory diseases described in Chapter 24. Particulate matter can cause or exacerbate diseases such as emphysema, bronchitis, and asthma. Coarse particles (10 microns in diameter - PM10) and fine particles (2.5 microns in diameter - PM2.5) are currently regulated. In Alaska, PM10 typically comes from windblown dust (glacial silt), volcanoes, and dirt roads. PM2.5 is man made and comes from wood burning stoves, open burning, home heating, and diesel and gas vehicles. Three areas in Alaska historically have problems with particulates: Juneau's Mendenhall Valley, Eagle River in the Municipality of Anchorage, and the Matanuska-Susitna Valley.

Alaska's cold climate contributes to air pollution problems, especially carbon monoxide levels. Approximately 80% of the winter carbon monoxide in cities is from vehicle emissions.

The Division of Environmental Health (DEC) ensures that sites contaminated by toxic chemicals are evaluated and cleaned up in priority order, based upon risk to human health and the environment. Currently there are over 2,000 sites considered contaminated. Over 500 of these are identified as "high priority" sites.

12. Food Safety

Goal: Reduce food borne illnesses.

The Division of Environmental Health in the Department of Environmental Conservation is responsible for the safety of Alaska's commercial food supplies. A variety of food products are processed in Alaska, including fish, meat, milk, syrups, candies, and bottled water. Alaska has 10 milk producers, 2 milk processors, and the only permitted reindeer slaughter facility in the U.S. In 2000, Alaska had 2,967 food service establishments, 778 food markets, 125 food processors, 368 school kitchens, and 500 temporary food vendors. The Municipality of Anchorage administers food service permits and inspections for more than 1500 food facilities in Anchorage.

Tribal health organizations are actively involved in a variety of programs to identify and assess contaminants in traditional subsistence foods. Botulism prevention is another area of interest. The Bristol Bay Health Corporation, for example, developed "Helping Hands," a web site and video to teach safer methods of food fermentation.

13. Oral Health

Goal: Prevent and control oral and craniofacial diseases, conditions, and injuries and improve access to related services.

Oral diseases are among the most prevalent health problems in the United States, especially among low-income children and the elderly, populations with limited access to routine dental care through private pay or health insurance.

Preliminary data from the 1999 Indian Health Service Oral Health Survey indicates the Alaska Native dental clinic user population has more than twice as many decayed or filled teeth as non-Natives.

The Head Start Program provided dental screening services to 2,186 of the 3,351 children enrolled in the program in FY99. Of the 2,186 children screened 73[illegible] ([illegible]4%) needed dental follow up for untreated dental disease.

Cleft lip with or without cleft palate is one of the most common birth defects, occurring at a rate of 1-2 cases out of 1,000 births. A high rate of cleft lip/palate is found in American Indian/Alaska Native populations, where as many as 1 infant in every 350 live births is affected. The Department of Health and Social Services sponsors pediatric Cleft Lip and Palate Clinics to serve Alaska residents.

Information collected in 2000 indicates approximately 43% of the total Alaskan population is served by a fluoridated community water system. Fluoridation is the single most effective and efficient means of preventing dental cavities in children and adults.

14. Vision and Hearing

Goal: Improve the visual and hearing health of Alaskans through prevention, early detection, treatment, and rehabilitation.

The U.S. Census Bureau estimates that of those Alaskans 16 and older, about 10,000 are visually impaired and another 1,300 are severely visually impaired.

Four hospitals in Alaska now perform routine hearing screening of newborns. Forty-six percent of the babies born in Alaska in 2000 were screened. With approximately 10,000 births annually, 20 to 30 infants would be expected to have congenital hearing impairments.

Many Alaskans have permanent, irreversible hearing loss from noise or trauma. Chainsaws, small aircraft, outboards, snow machines, guns, and all-terrain vehicles are common sources of high-decibel sound which can create hearing loss.

Otitis media (ear infections) are common health problems, especially among rural Alaska Native children. The Alaska Federal Health Care Access Network Telemedicine Project for videootoscopy screening in underserved areas of the State will help to ensure that children with otitis are treated appropriately.

The Infant Learning Program provides services to visually or hearing impaired children under three years of age. Special education services may be available from age three to 22 through local school districts. Alaska Vocational Rehabilitation serves older children and adults whose ability to work is impaired by visual or hearing disabilities.

Preventive Services and Access to Care

Preventive services include counseling, screening, immunization, and medical interventions offered to individuals in clinical settings. Alaska's size and geography make access to physical and behavioral health care a crucial issue, especially for rural residents. Low income and lack of adequate health insurance further limit access to needed treatment. Access to preventive and treatment services for mental health and for alcohol and other substance abuse is addressed in the relevant chapters in the "health promotion" cluster. However, many of the same barriers related to cost, transportation, and acceptability of services apply to these services as well as to the services addressed in the cluster of chapters on "preventive services and access to care."

15. Access to Quality Health Care

Goal: Improve access to comprehensive, high-quality health care services.

Alaska experiences many health and health care delivery challenges that are different from those of the rest of the United States. With 226 federally recognized tribes, 162 local governments, numerous federal and state supported health associations, five community health centers, and many privately run clinics, Alaska is unique. Tribal health care facilities are the only providers in most rural areas.

Approximately 75% of Alaskan communities are not connected by road to a community with a hospital. Air travel within Alaska is expensive, and many rural residents have little cash income. The geography of the state, therefore, contributes to the high cost of health care.

The State Children's Health Insurance Program, Denali KidCare in Alaska, implemented in 1999, provides a mechanism for increasing the proportion of children with an ongoing source of health care. Due to policy changes that expanded enrollment to 200% of the poverty level and to aggressive outreach efforts, over 16,000 children became eligible for health insurance. As of December 2000, a total of 53,140 children are covered through Denali KidCare and Medicaid.

Alaska is first in the nation in the proportional growth of our senior population – with a 50% increase in people aged 65 years and older between 1990-1999. An increase in the number of elderly and adults with disabilities in Alaska means a dramatic increase in the number of people needing long-term care services. The Long-Term Care Implementation Team was organized in 1996 as a method for policy makers in the Departments of Administration and Health and Social Services to identify a comprehensive long range strategy to guide long-term care development in the state.

16. Maternal, Infant, and Child Health

Goal: Improve the health and well-being of women, infants, children, and families.

The infant mortality rate is made up of two components: neonatal mortality (death in the first 28 days of life) and postnatal mortality (death after the first month but within the first year). The leading causes of neonatal death include birth defects, disorders related to short gestation and low birth weight, and pregnancy complications. Alaska's 1999 neonatal death rate, at 3.6 per 1,000, is lower than the U.S. rate of 4.7 per 1,000 for the same year.

In 1999, Alaska's post neonatal death rate was 3.0 per 1,000, compared to a U.S. rate of 2.3 per 1,000. The leading cause of postneonatal death in Alaska is Sudden Infant Death Syndrome (SIDS) and other unexplained asphyxial death. Alaska Natives have over twice the risk of infant death due to SIDS.

Parent education will play an important role in reducing SIDS deaths in Alaska.Despite the common occurrence of physiological abnormalities and parental drug use (both known risk factors for SIDS) among infants who die of SIDS in Alaska, deaths rarely occur in the absence of mechanical risk factors such as prone sleeping, sleeping with another person or sleeping outside of a standard infant crib. Educational intervention includes teaching caregivers to use a firm surface under the infant and to remove all soft or loose items from the sleep environment.

The Alaska Maternal and Infant Mortality Review Committee reviews all infant deaths to assess risk factors and prevention opportunities. The Committee estimates that about 34% of infant deaths in Alaska are preventable.

About 80% of Alaska women seek prenatal care during the first trimester of pregnancy. The proportion of mothers who received adequate prenatal care during pregnancy has decreased since 1994. Sixty-seven per cent of women who delivered live births in 1999 received adequate care during the prenatal period compared to 71% in 1990 and 74% in 1995. Only 47% of Alaska Native mothers received adequate care in 1999.

Many Alaskan women face significant barriers to obtaining adequate prenatal care. Even when reimbursement is assured through tribal health associations or Medicaid, pregnant women may have to travel great distances for care and face long waiting periods in busy clinics or hospitals. Those living in remote villages may have to leave families and jobs for three days or more to make a single prenatal visit.

Approximately one in five women who deliver a live birth in Alaska smokes cigarettes during the last three months of pregnancy, one in 25 drinks alcohol, one in 25 uses marijuana and one in every 500 women who deliver a live birth uses cocaine during pregnancy.

The Alaska Fetal Alcohol Syndrome Prevention Project found the prevalence of fetal alcohol syndrome in Alaskan children born during 1977-1992 to be 0.8 per 1,000 births. The study also found that fetal alcohol syndrome occurred disproportionately in Alaska Native children born during those same years at 3.0 per 1,000 births.

Adequate consumption of the vitamin folic acid prior to conception and early in pregnancy reduces the risk for neural tube defects, serious birth defects that may cause death or disability. The Alaska Folic Acid Committee seeks to increase the number of Alaskan women of childbearing age who consume adequate amounts of folic acid. The Committee, formed in 1999, provides educational programs and conducts promotional activities.

Breast-feeding is one of the best ways to improve infant health. Breast-feeding initiation rates in Alaska are excellent and the trend has been increasing over the years — from 84% in 1993 to 86% in 1997.

Alaskan children aged 1-4 have up to 1.5 times the risk of death as other American children. Most of the deaths occurring during childhood are preventable. In Alaska and in the U.S., the leading cause of death for children of all ages is injury. Four of the top five causes of childhood death in Alaska are a result of fatal injuries: motor vehicles, drowning, burns and firearms.

17. Family Planning

Goal: Improve pregnancy planning, birth spacing and prevent unintended pregnancy.

In Alaska, the Pregnancy Risk Assessment Monitoring Survey measures the intendedness of live births by asking a woman, who has delivered within the past three months, whether she became pregnant when she *wanted to be* pregnant. It is difficult to measure an unintended pregnancy in Alaska, due to a lack of data on pregnancy terminations and spontaneous abortion. There has been no decline in the proportion of live births that occur as a result of unintended pregnancy in Alaska since 1990. In 1998, 43% of live births were unintended.

Alaska has the second highest fertility rate among the 50 states. While the total fertility rate for Alaska (71.4 per 1,000) remains considerably higher than the national average (65.4 per 1,000), the teen birth rate in Alaska (47.8 per 1,000 females age 15-19 in 1999) declined substantially over the last decade. Between 1990 and 1999, the birth rate for Alaska females age 15 to 19 declined by 30% and is now slightly lower than the national teen birth rate of 51 births per 1,000 females.

Family planning services in Alaska are funded through the Maternal, Child, and Family Health program by the allocation of federal funds and resources and state funds. Collaborative agreements with private non-profit agencies such as Community Health Centers and Planned Parenthood complete the service delivery network. Women receiving Medicaid benefits can also access family planning services through private medical providers who accept Medicaid. Family planning services are also available through tribal health organizations, private providers, and Planned Parenthood of Alaska clinics in Anchorage, Sitka, and Soldotna.

18. Immunizations and Infectious Diseases

Goal: Prevent disease, disability, and death from infectious disease, including vaccine-preventable diseases.

The reduction in the incidence of and mortality from infectious diseases has been a significant public health achievement in Alaska during the past 50 years. Despite the progress that has been made, infectious diseases remain a significant cause of illness and death in Alaska. Alaska continues to have the highest rate of invasive *Haemophilus influenzae* group B (Hib) in the nation. *Streptococcus pneumoniae*, a leading cause of pneumonia, ear infections, and meningitis, is now increasingly resistant to antibiotics. Other common infections in Alaska include Hepatitis C, *Helicobacter pylori*, and respiratory syncytial virus (RSV).

Alaska Natives continue to suffer from higher rates of tuberculosis and invasive *H. influenzae* and *S. pneumoniae* disease. Alaskan Natives with chronic Hepatitis B infection experience high rates of liver disease and liver cancer. Severe RSV disease in Alaska Native infants results in high rates of hospitalization and chronic lung disease. Community-acquired methicillin resisitant *Staphylococcus aureas* (MRSA) is now endemic in some rural Alaska Native communities.

Changes in the state immunization schedule should decrease the incidence of several additional common communicable diseases. Varicella and pneumococcal conjugate vaccines have been added to the routine childhood immunization schedule. School immunization requirements now include Hepatitis A and B immunization, and child care facilities now require Hib and varicella vaccines as well as Hepatitis A and B.

Tuberculosis remains a major public health issue in Alaska. In 1946, 43% of all death certificates of Alaska Natives listed tuberculosis as the cause of death. Cases of tuberculosis have declined greatly, but significant village and family outbreaks continue to occur. Alaska had the highest rate of tuberculosis in the nation in 2000.

The Section of Epidemiology of the State of Alaska Division of Public Health is responsible for the surveillance, investigation, and control of infectious diseases. The Public Health Laboratory in Anchorage provides reference and diagnostic services in serology, parasitology, bacteriology, and mycology. The Fairbanks Public Health Laboratory provides the only virology services in the state, and participates in the international surveillance of influenza isolates.

The Alaska Native Epicenter conducts epidemiological research for the Alaska Tribal Health Consortium. The Viral Hepatitis Program at the Alaska Native Medical Center researches the natural history of vital hepatitis and prevention and treatment of liver disease among Alaska Natives.

The Centers for Disease Control's Arctic Investigations Program in Anchorage provides support for infectious disease prevention. Current research projects include antimicrobial resistance, *Haemophilus influenzae*, *Helicobacter pylori*, respiratory syncytial virus, *Streptococcus pneumoniae*, viral hepatitis, and an arbovirus serosurvey.

19. HIV Infection and Sexually Transmitted Diseases

Goal: Prevent sexually transmitted diseases (STDs) and Human Immunodeficiency Virus (HIV) infection and treat infections to reduce their impact on health.

Gonorrhea infection rates in Alaska have declined significantly in all populations since 1990. A total of 362 cases of gonorrhea were reported in Alaska in 2000. A total of 6 cases of syphilis were reported in Alaska in 2000, and none of these were currently infectious syphilis. No cases of congenital syphilis have been reported in Alaska since 1979.

Chlamydia infection was the most frequently reported disease in Alaska in 2000, with 2,570 cases reported. In 2000, Alaska was ranked second highest in the U.S. in its chlamydia case rate. The increased number of cases most likely results from better case finding due to the introduction of targeted chlamydia screening, use of new urine screening technologies, and increased partner notification activities in 2000 rather than from an actual increase in the amount of disease.

A cumulative total of 781 cases of HIV infection were reported to the Division of Public Health through December 31, 2000. Of these 781 cases, 544 were reported with AIDS and 237 with HIV infection without AIDS. From 1996-2000, an average of 38 newly diagnosed cases of HIV infection (with or without AIDS) per year were reported in Alaska. The mean annual incidence rate of reported AIDS cases in Alaska residents diagnosed from 1996-2000 was 4.4 cases per 100,000 population. (Because there are small numbers of cases diagnosed from year to year in Alaska, the mean annual rate is used to give a more reliable estimate of the AIDS incidence rate over that time period). This rate

compares to an annual incidence rate for AIDS cases reported in the U.S. from July 1999 through June 2000 of 15.7 cases per 100,000 population.

A number of health care providers in the public and private sectors around the state offer screening services and clinical treatment for STD and HIV disease. Screening and diagnostic laboratory services for STD and HIV are offered through the State Public Health Laboratory as well as through many private laboratories.

Tribal health organizations provide culturally appropriate STD and HIV prevention and treatment services. The Alaska Native Health Board (ANHB) established the HIV/AIDS Awareness program in 1988. Training, technical assistance, and informational materials are distributed through ANHB membership organizations.

20. Arthritis and Osteoporosis

Goal: Prevent ill health and disability related to arthritis, other rheumatic conditions, and osteoporosis.

The Arthritis Foundation, Washington/Alaska Chapter has a growing presence in Alaska. The Arthritis Foundation has established five exercise/support group programs in the state and recently received a grant from their national organization to build 20 self-help programs throughout the state.

The Alaska Department of Health and Social Services established an arthritis program in 1999, and an advisory group was formed in 2000 to develop a coordinated arthritis prevention and management plan for Alaska.

Alaska does not yet have a uniform hospital discharge data reporting system. Hospital discharge data on hip and vertebral fractures related to osteoporosis could be used to establish baselines and to monitor progress.

21. Heart Disease and Stroke

Goal: Improve cardiovascular health and quality of life through the prevention, detection, and treatment of risk factors; early identification and treatment of heart attacks and strokes; and the prevention of recurrent cardiovascular events.

Heart disease is the second leading cause of death in Alaska, and cerebrovascular disease (most commonly referred to as stroke) is the fourth leading cause of death in Alaska. In Alaska the age-adjusted death rate for heart disease has been consistently lower than the U.S. rate. Many Alaskans are currently at risk for developing cardiovascular disease due to risk factors such as smoking, overweight, poor diet, sedentary lifestyle, high blood pressure and cholesterol, and lack of preventive health screening.

The Division of Public Health, with the American Heart Association, Alaska Affiliate, the Alaska Health Fair Inc. and many individuals and representatives from many other agencies and organizations, completed the statewide Cardiovascular Disease Prevention Plan 1998.

Prompt response to heart attacks prevents death and severe impairment. The Division of Public Health, Section of Community Health and Emergency Medical Services oversees training and certification of Emergency Trauma Technicians and Medical Technicians. One of the goals of the state is to increase the proportion of persons who have access to rapidly responding pre-hospital emergency medical services by developing early defibrillation programs in all communities that meet the American Heart Association's criteria.

22. Cancer

Goal: Reduce the number of new cancer cases, as well as the illness, disability, and death caused by cancer.

Cancer was rarely seen in Alaska during the 1950s, but in the 1990s cancer was the leading cause of death in Alaska. In 1999, an estimated 1,930 persons in Alaska were diagnosed with cancer and 623 died from cancer. Lung cancer is the most common cause of cancer death among both males and females in Alaska, and in 1999 accounted for 30% of all cancer deaths. Cigarette smoking is the most important risk factor for lung cancer. Smoking cessation and 10 years of abstinence decreases the risk of lung cancer to 30% to 50% of that of continuing smokers.

The mortality rate for cancer (overall) was higher for Alaska Natives than for all Alaskans during 1991-1998.

The Alaska Cancer Registry was established in 1996. The Registry collects data on all newly diagnosed cancer cases and receives mortality data from the Bureau of Vital Statistics.

23. Diabetes

Goal: Reduce the physical, emotional, and economic burden of diabetes and improve the quality of life of all persons who have or are at risk for diabetes.

The prevalence of diabetes in Alaska is measured among adults using the Behavioral Risk Factor Surveillance System. Approximately 14,000 adults, 3.5% of the adult population, have been diagnosed with diabetes. An estimated 3,600 (11%)of Alaskans over 65 have diabetes.

The highest prevalence of diabetes in Alaska is found among African Americans (4.6%) and Hispanics (4.4%). American Indians and Alaska Natives are also at increased risk for diabetes, but prevalence varies significantly among tribes. Alaskan tribes had the lowest prevalence rate among tribes surveyed by the Indian Health Service in 1997. Among Alaska Native groups, diabetes prevalence is highest among Aleuts and lowest among groups in the northwest.

The State of Alaska Diabetes Control Plan details state and community strategies for diabetes prevention and the reduction of complications associated with diabetes. The Alaska Area Diabetes Model Program maintains a diabetes registry and actively monitors care and preventive practices among Alaska Natives. Such surveillance is much more difficult to accomplish among the remaining 82% of the population. Full surveillance of diabetes in Alaska will require the use of a hospital discharge data system.

24. Respiratory Diseases

Goal: Promote respiratory health through better prevention, detection, treatment, and education efforts.

The National Health Interview Survey estimated self-reported asthma prevalence at 6.7% for Alaska in 1998, essentially identical to the national average.

Respiratory syncytial virus (RSV) associated disease is the major cause of hospitalization for Alaska Native infants, with babies in the Yukon-Kuskokwim Delta at highest risk. Hospitalization rates as high as 249 per 1,000 have been reported for infants in western Alaska, in contrast to rates of 1 to 20 per 1,000 in the U.S.

Chronic obstructive pulmonary disease (COPD) is the sixth leading cause of death in Alaska. The COPD death rate among Alaska Natives, 30 per 100,000, is almost double the rate for whites. Since Alaskans 65 and over accounted for 78% of all COPD deaths, more cases will be expected as the population continues to age.

Smoking prevention and cessation and protection from second-hand smoke are the foundations of respiratory disease prevention. The increase in state tobacco tax, which has led to reductions in the sales of taxable products, and restrictions on smoking in public areas, such as those recently enacted in Bethel and Anchorage, are currently the most effective strategies for reducing COPD, asthma, and RSV.

Hospital discharge data are the most effective ways of tracking COPD, asthma, and RSV disease. If the Division of Public Health initiates review of hospital discharge diagnoses, baseline information on rates of these serious respiratory diseases can be established.

25. Disability and Secondary Conditions

Goal: Promote the health of people with disabilities, prevent secondary conditions, and eliminate disparities between people with and without disabilities in the U.S. population.

More and more Alaskans with severe disabilities are living in their own homes or with their families. Alaska is the first state in the country to eliminate public and private institutions for people with developmental disabilities. However, many individuals with disabilities must still live in nursing homes to get the services and supports they need.

Several studies have demonstrated that health promotion programs focused on improving functioning across a spectrum of diagnoses and a range of age groups are effective in reducing secondary conditions and outpatient physician visits among people with disabilities. For example, a focus on improving muscle tone, flexibility, and strength can benefit people who use wheelchairs and people with arthritis.

For people with disabilities to have the opportunity for healthy lives, both physically and emotionally, programs and facilities that offer wellness and treatment services must be fully accessible. Effective enforcement of the American with Disabilities Act can improve services and help prevent secondary disabilities.

The call for statistics on people with disabilities is longstanding. To remedy these gaps, survey questions have been developed and tested to identify individuals with varying degrees of disability in terms of activity limitations. These survey questions are now included as a rotating core of the BRFS System.

Public Health Infrastructure

The Public Health Infrastructure chapter is addressed in a separate, stand-alone section of *Healthy Alaskans 2010* because it addresses issues that affect needs described in every other chapter.

The public health infrastructure supports the planning, delivery, and evaluation of public health activities and practices. This infrastructure makes it possible to respond to public health emergencies, as well as to perform on-going essential public health services. Workforce, information and data systems, and effective organizations are the elements that comprise the infrastructure, providing the capacity to deliver the programs and services that protect and promote the health of Alaskans. These elements are interrelated. Weaknesses in any one element affect the other two.

The mission of the public health system is to fulfill society's interest in assuring conditions in which persons can be healthy. The public health system is a network of public and private organizations and individuals involved in accomplishing this mission. The framework for what the public health system strives to accomplish and the method of doing so is captured in the statement "Public Health in America" (Figure 17), developed by the national Public Health Functions Task Force in 1994. As with the elements of the public health infrastructure, the various partners in the public health system are also interrelated. A deficiency in one sector or jurisdiction affects the entire system.

Figure 17

Public Health in America

***Vision:** Healthy People in Healthy Communities*

***Mission:** Promote Physical and Mental Health and Prevent Disease, Injury, and Disability*

Public Health

- Prevents epidemics and the spread of disease
- Protects against environmental hazards
- Prevents injuries
- Promotes and encourages healthy behaviors
- Responds to disasters and assists communities in recovery
- Assures the quality and accessibility of health services

Essential Public Health Services

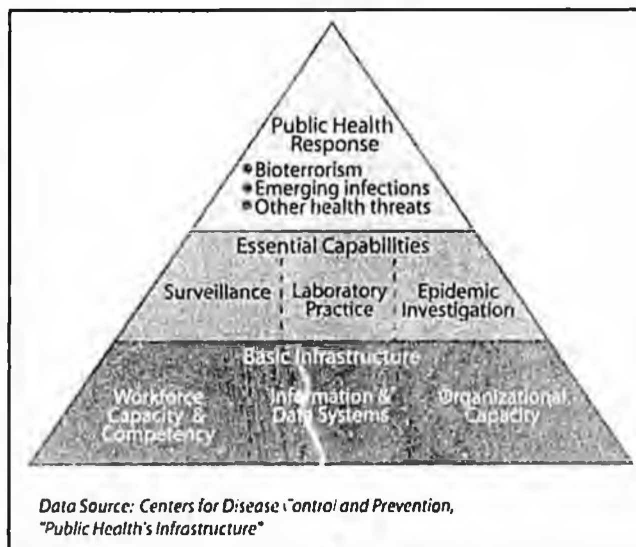
- Monitor health status to identify community health problems
- Diagnose and investigate health problems and health hazards in the community
- Inform, educate, and empower people about health issues
- Mobilize community partnerships to identify and solve health problems
- Develop policies and plans that support individual and community health efforts
- Enforce laws and regulations that protect health and ensure safety
- Link people to needed personal health services and assure the provision of health care when otherwise unavailable
- Assure a competent public health and personal health care workforce
- Evaluate effectiveness, accessibility, and quality of personal and population-based health services
- Research for new insights and innovative solutions to health problems

Adopted: Fall 1994 Source: Public Health Functions Steering Committee, Members (July 1995): American Public Health Association Association of Schools of Public Health Association of State and Territorial Health Officials Environmental Council of the States National Association of County and City Health Officials National Association of State Alcohol and Drug Abuse Directors National Association of State Mental Health Program Directors Public Health Foundation U.S. Public Health Service —*Agency for Health Care Policy and Research Centers for Disease Control and Prevention Food and Drug Administration Health Resources and Services Administration Indian Health Service National Institutes of Health Office of the Assistant Secretary for Health Substance Abuse and Mental Health Services Administration*

26. Public Health Infrastructure

Goal: Ensure that state, local, and tribal health agencies have the infrastructure to provide essential public health services effectively.

A number of factors are straining the public health system and necessitating now, as never before, a strong public health infrastructure. These factors include new public health threats; a growing and changing population; and rapidly developing medical, information, and communication technologies.



Data Source: Centers for Disease Control and Prevention, "Public Health's Infrastructure"

• New Public Health Threats: As we enter this millennium we face threats to the public's health not imagined a century ago. The use of microbial agents as weapons against our citizens has elevated the visibility of the role the public health system plays in detection and control of communicable diseases, and is spreading the surveillance, laboratory, epidemiological investigation, and emergency response capacities dangerously thin. This is occurring at a time when other natural and manmade threats, such as a recent resurgence of TB in Alaska, increasing diagnoses of hepatitis C, groundwater pollution and hazardous waste management are competing for limited public resources.

• Changing Demographics: Births in Alaska continue to outnumber deaths each year, sustaining the upward trend in Alaska's population size. At the same time there is an upward trend in the proportion of elderly Alaskans and in the proportion of some minorities. Increased total numbers of people coupled with even greater increases in vulnerable populations puts pressure on the public health system as it struggles to keep up with the growing demand for services with limited resources.

• New Technologies: New medical technologies, such as vaccines developed in recent years to fight varicella and hepatitis A, are valuable weapons for continuing the battle against communicable diseases. As these new tools become available, however, they require resources for purchase and administration. New data and communication technologies provide opportunities for strengthening information-based decision making and public health surveillance, but also require additional or redirected resources and the development and implementation of new strategies.

Elements of the public health infrastructure requiring reinforcement include:

• Workforce: A qualified, competent public health workforce is essential to the effective delivery of public health programs and services. Issues facing the maintenance of skilled employees and adequate staffing levels include: 1) an aging workforce (just as an example, 32% of health professionals in the Alaska Department of Health and Social Services will be eligible for retirement during the first half of this decade); 2) increased competition for a decreasing supply of public health workers nationwide (compensation must be high enough to recruit and retain qualified staff); and 3) a need for increased access to public health training and continuing education opportunities.

• Data and Information Systems: Timely access to accurate data and information are essential to the planning, development, implementation, and evaluation of public health programs and services. Related issues include: 1) a need to assure that all public health workers have electronic access to up-to-date public health information and emergency health alerts; 2) a need for increased access to public health information by the public and policy makers; 3) data gaps identified throughout this report that must be addressed to provide a complete picture of the health of Alaskans and to understand health trends in our communities; and 4) new privacy protection standards, such as those required under the 1996 Health Insurance Portability and

Accountability Act, that are affecting the handling of public health data sets and systems.

- **Organizational Capacities:** Elements of an effective public health organization include: 1) an ability to meet basic performance and accountability standards (for example, standards for laboratory testing capacity, disease surveillance, and emergency response), 2) maintenance of sufficient legal authorities for governmental public health agencies; 3) capacity for planning and policy development at the state and local levels; and 4) the capability to provide leadership and to collaborate with public health system partners.

While the public health infrastructure in Alaska is under serious pressure, there are a number of strategies targeted at strengthening it and building the capacity of our public health system to respond to public health emergencies and other health threats. Current strategies and resources include:

- Increased awareness of and support for the state's public health infrastructure by the executive and legislative branches of Alaska's state government in recent years. Specific examples include: 1) funding for a new state-of-the-art public health laboratory in Anchorage with Biosafety Level III capacity (opened January 2001); 2) development by Governor Knowles and partial funding by the legislature in 2001 of the Back-to-Basics Initiative, which provides new state resources for fundamental disease surveillance and control efforts in Alaska; and 3) dedication by the state legislature of 20% of the tobacco settlement revenue for public health tobacco use prevention and cessation efforts.

- A growing focus by the federal government on support for state and local public health infrastructure, evidenced through such initiatives as: 1) the Public Health Preparedness and Response for Bioterrorism grant, awarded to Alaska in 1999, to build capacity for training, emergency alert communication, and disaster planning and response; and 2) the inclusion of a new section in Healthy People 2010 devoted to public health infrastructure issues.

- Continuing attention to the importance of public health by Alaska's tribal health system. As one example, the Alaska Native Tribal Health Consortium included as the first goal in their 2000-2005 Strategic Plan to "Increase emphasis on health promotion and disease prevention."

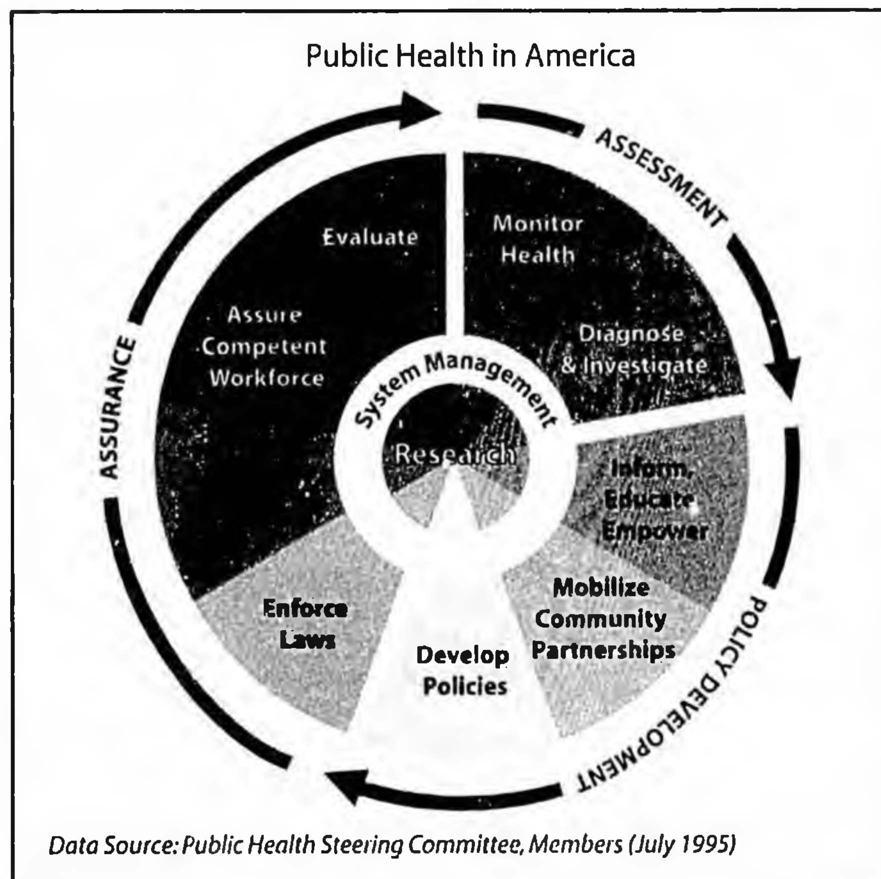
- Interest and commitment to strengthening the nation's public health system by private, philanthropic organizations such as the Robert Wood Johnson and W.K. Kellogg Foundations. These two foundations partnered on the Turning Point initiative, which began in 1996 and is continuing through the first half of the new decade. Alaska and three of our communities, Fairbanks, Sitka, and Central Kenai Peninsula, received grants under this program. Goals identified by Alaska's Turning Point project, the Alaska Public Health Improvement Process, are listed in Figure 18. Current activities to address these goals include public health information system development, leadership of a national effort to create a model state public health law, and participation in a collaborative project on public health performance management.

- Other important public health partners working to address health workforce, data and communication issues include the Municipality of Anchorage Department of Health & Human Services, the University of Alaska, the Alaska Mental Health Trust Authority, the Alaska State Hospital and Nursing Home Association, and the Alaska State Medical Association.

Figure 18. Alaska Public Health Improvement Plan Goals

Goals Adopted by the Alaska Public Health Improvement Process Steering Committee 1999

1. Assure access to public health information for communities, policy makers, and the general public
2. Assure a well-trained, competent public health workforce
3. Develop a strong legal framework for Alaska's public health system
4. Assure accountability for the public's health
5. Assure sufficient, stable funding for public health action
6. Assure effective communication capabilities in the public health system
7. Increase public input in statewide policy decisions
8. Engage communities to solve local health problems
9. Increase personal responsibility for individual health
10. Improve interagency communication, coordination, and collaboration between state public health, mental health, substance abuse and environmental health agencies



Data Source: Public Health Steering Committee, Members (July 1995)

Appendices

Appendix A Healthy Alaskans Partnership Council Members
Appendix B Chapters and Main Authors
Appendix C Abbreviations
Appendix D Technical Notes

Appendix A: Healthy Alaskans Partnership Council Members and Alternates, and the Organizations or Communities they are representing on the Council:

Bill Allen	Cordova Center
Donna Bacon,	US Air Force, 3AMDS/SGPM
Mike Conway, Kristin Ryan*, Bill Stokes*	Alaska Department of Environmental Conservation
Kathy Craft, Jean Becker*, Cecile Lardon	Fairbanks Turning Point Partnership
Kathryn Davey	Alaska Health Education Consortium
Laraine Derr	Alaska State Hospital & Nursing Home Association
Traci Davis, Robert Ruffner*, Stan Steadman*	Central Kenai Peninsula Turning Point Partnership
Joan Dornnick (through July 2001)	Alaska Native Tribal Health Directors
Fred Dyson, Johnny Ellis	Alaska State Legislature
Charlie Fautin (through July 2001)	Maniilaq Health Services Turning Point Project
Mark Hamilton, Denny DeGross*	University of Alaska
Lisa Sadleir-Hart, Auriella Hughes*, Cindy Baldwin-Kitka*, Laura Wertz-Stein*	Sitka Turning Point Partnership
Jeff Jessee, Delisa Culpepper*, Mary Elizabeth Rider*	Alaska Mental Health Trust Authority
Walter Majoros	Division of Mental Health & Developmental Disabilities, Alaska DHSS
Jewel Jones, Nancy Merriman*	Municipality of Anchorage, Health & Human Services
Peter Nakamura, MD	Technical Advisor on Alaska Health Issues and Systems
James Jordan	Alaska State Medical Association
Cheryl Kilgore	Interior Neighborhood Health Clinic
Carmen Rosa D.C. Mallipudi	Hispanic Organized Leaders of Alaska
Christopher Mandregan	Alaska Area Native Health Service
Bonnie McMahon, Diane MacMillan*	Charter North, Residential Treatment Center
Cynthia Navarrette	Alaska Native Health Board
Brenda Norton	Anchorage Health & Human Services Commission
Karen Pearson	Division of Public Health, Alaska DHSS
Jay Livey	Alaska Department of Health & Social Services
Janet Clarke	Division of Administrative Services, Alaska DHSS
Richard Rainery	Alaska Mental Health Board
Rhonda Richtsmeier	Alaska Public Health Association
Susan Rinker	North Slope Borough Dept. of Health and Social Services
Carl Rose, Derek Peterson*	Association of Alaska School Boards
Brian Saylor, Ph.D.	University of Alaska, Anchorage, Institute for Circumpolar Health Studies
Paul Sherry, Tom Lefebvre*	Alaska Native Tribal Health Consortium
Ernie Turner Susan Soule*	Division of Alcoholism and Drug Abuse, Alaska DHSS
Deborah Vo	Alaska Inter - Tribal Council
Peter Wallis	Alaska Environmental Health Association
Pam Watts	Governor's Advisory Board on Alcoholism & Drug Abuse

Appendix B. Chapters and Main Authors

Healthy Alaskan Chapter	Main Author	State of Alaska Affiliation (see Appendix C for Abbreviations)
1. Physical Activity and Fitness	Garry Lowry	DHSS, DPH, CHEMS
2. Nutrition and Overweight	Diane Peck	DHSS, DPH, MCFH
3. Tobacco Use	Wayne Coolidge	DHSS, DPH, CHEMS
4. Substance Abuse	Pam Watts Marilee Fletcher Lynn Hutton	DHSS, Governor's Advisory Board on Alcoholism and Drug AbuseDHSS, DMHDD
5. Mental Health	Kathryn Cohen	DHSS, DAS, Facilities and Planning
6. Educational and Community-based Programs	Jayne Andreen Delisa Culpepper	DHSS, DPH, CHEMS Department of Revenue, Mental Health Trust Authority
7. Health Communication	Patty Owen	DHSS, DPH, CHEMS
8. Injury Prevention	Martha Moore	DHSS, DPH, CHEMS
9. Violence and Abuse Prevention	Martha Moore Susan Keady	DPH, CHEMS, DHSS, DPH, Data and Evaluation Unit
10. Occupational Safety and Health	Deborah Choromanski	DHSS, DPH, Epidemiology
11. Environmental Health	Kristin Ryan Sandy Smith	DEC, Environmental Health, DEC, Statewide Public ServiceDEC, State wide Public Service
12. Food Safety	Kristin Ryan Sandy Smith	DEC, Environmental Health, DEC, Statewide Public Service
13. Oral Health	Brad Whistler	DHSS, DPH, Directors Office
14. Vision and Hearing	Barb Sylvester-Pellet Diane DeMay	DHSS, DPH, Nursing
15. Access to Quality Health Care	Pat Carr Anthony Zenk Shelley Owens Kay Branch	DHSS, DPH, CHEMS
16. Maternal, Infant and Child Health	Janine Schoellhorn	DHSS, DPH, MCFH
17. Immunizations and Infectious Diseases	Beth Funk	DHSS, DPH, Epidemiology
18. Family Planning	Janine Schoellhorn Mary Diven	DHSS, DPH, MCFH

19. HIV Infection and Sexually Transmitted Diseases	Wendy Craytor	DHSS, DPH, Epidemiology
20. Arthritis and Osteoporosis	Paige Lucas	DHSS, DPH, Epidemiology
21. Heart Disease and Stroke	Patty Owen	DHSS, DPH, CHEMS
22. Cancer	Jeanne Roche	DHSS, DPH, Epidemiology
23. Diabetes	Judy Sberna	DHSS, DPH, Epidemiology
24. Respiratory Diseases	Susan Keady	DHSS, DPH, Data and Evaluation Unit
25. Disability and Secondary Conditions	Millie Ryan	DHSS, Governor's Council on Disabilities Special Education
26. Public Health Infrastructure	Deb Erickson	DHSS, DPH, Directors Office

* Alternates; meetings are open meetings

Appendix C. Abbreviations used in Healthy Alaskans 2010

ABVS - Alaska Bureau of Vital Statistics

ACoA - Alaska Commission on Aging

ACR - Alaska Cancer Registry

ADA - Alaska Division of Alcoholism and Drug Abuse

AFHCAN - Alaska Federal Health Care Access Network

AIPC - Alaska Injury Prevention Center Observation Study

AKPCA - Alaska Primary Care Association

AMHB - Alaska Mental Health Board

AMIMR - Alaska Maternal Infant Mortality Review

ANHB - Alaska Native Health Board

ANTHC - Alaska Native Tribal Health Consortium

ARORA - Mental health database obtained from mental health direct service providers

ASHNHA - Alaska State Hospital and Nursing Home Association

ASMA - Alaska State Medical Association

ASOII - Annual Survey of Occupational Injuries and Illnesses, DOL

ASSE - American Society of Safety Engineers

ATR - Alaska Trauma Registry

BMI - Body Mass Index=weight (kg)/(height (meters))^2

BRFSS - Alaska Behavioral Risk Factor Surveillance System

CDC - Centers for Disease Control and Prevention

CHEMS - Community Health and Emergency Medical Services

DCED - Alaska Department of Community and Economic Development

DEC - Alaska Department of Environmental Conservation

DEED - Alaska Department of Education and Early Development

DFYS - Alaska Division of Family and Youth Services

DHSS - Alaska Department of Health and Social Services

DJJ - Alaska Division of Juvenile Justice

DMA - Division of Medical Assistance

DMHDD - Alaska Division of Mental Health and Developmental Disabilities

DOC - Alaska Department of Corrections

DOL - Alaska Department of Labor and Workforce Development

DOT&PF - Alaska Department of Transportation and Public Facilities

DOT&PF - Department of Transportation and Public Facilities

DOT, NHTSA - Department of Transportation, National Highway Traffic Safety Administration

DPH - Alaska Division of Public Health

EH - Environmental Health

EHDI - State-based Early Hearing Detection and Intervention Program Network, CDC

EMS - Emergency Medical Services

EMT - Emergency Medical Technician

EPA - Environmental Protection Agency

EPSDT - Early and Periodic Screening, Diagnosis and Treatment

FANR - Food Assistance and Nutrition Research

FARS - Fatality Analysis Reporting System

FAS - Fetal Alcohol Syndrome

HCUP - Healthcare Cost Utilization Project

HRSA - Health Resources and Services Administration

ISER - Institute for Social and Economic Development Observation Study

ICD 9 and ICD 10 – International Classification of Diseases, Version 9 and Version 10

LTC - Long Term Care

MEPS - Medical Expenditure Panel Survey

MHSIP - Mental Health Statistics Improvement Program

MCH - Bureau of Maternal Child Health (HRSA)

MCFH - Section of Maternal, Child and Family Health (DPH)

MOA - Municipality of Anchorage

NCHS - National Center for Health Statistics

NHANES - National Health and Nutrition Examination Survey

NHDS - National Hospital Discharge Survey

NHIS - National Health Interview Survey

NHSDA - National Survey on Drug Abuse

NIOSH - National Institute of Occupational Safety and Health

NSB - North Slope Borough

NSFG - National Survey of Family Growth

NTIA - National Telecommunications and Information Administration

NVSS - National Vital Statistics System

PedNSS - Pediatric Nutrition Surveillance System

PNSS - Pregnancy Nutrition Surveillance System

PRAMS - Alaska Pregnancy Risk Assessment Monitoring System

RPMS - Resource Patient Management System

RSV - Respiratory Syncytial Virus

SAMHSA - Substance Abuse and Mental Health Services Administration

SDWA - Safe Drinking Water Act

SNF - Skilled Nursing Facility

SPAPECD - Survey of Physicians' Attitudes and Practices in Early Cancer Detection

UAA - University of Alaska, Anchorage

UAF - University of Alaska, Fairbanks

UCR - Uniform Crime Report, Federal Bureau of Investigation

USDA - United States Department of Agriculture

USDOL/BLS - United States Department of Labor, Bureau of Labor Statistics

WIC - Women, Infants and Children

YRBS - Alaska Youth Risk Behavior Survey

Appendix D. Technical Notes

Age Adjustment

In Healthy Alaskans 2010 all vital statistics data is age adjusted to the standard United States (million) 2000 population. Age-adjusted rates are calculated so comparisons can be made between populations that have different age distributions. For example, since Alaska has a lower proportion of people over 65 than the United States, it will experience a lower crude death rate. Many chronic disease indicators, such as cancer and diabetes, are strongly associated with age, and accurate comparisons can be made only with age adjustment.

Behavioral Risk Factor Surveillance System (BRFSS)

Many Healthy Alaskans 2010 indicators are tracked through the Behavioral Risk Factor Surveillance System (BRFSS) system. This data collection process was implemented in Alaska as an ongoing surveillance system in 1991. Alaska adults, age 18 years old and older, are interviewed regarding their health and day-to-day living habits. Households with a telephone are selected by a scientifically designed and conducted random telephone survey. The survey is designed to report population prevalence at a region or state level. Alaska's BRFSS (1998 or later) supports five geographic regions generally described as Anchorage and vicinity, Gulf Coast, Southeast, Rural, and Fairbanks and vicinity. The U.S. baseline values represent the national median using the number of States collecting the same information through their BRFSS systems, and are age-adjusted to the standard million population. Furthermore, Alaska BRFSS data is not age-adjusted to the US standard million because of the added complexity of this step for within-state analysis. Trends can be observed between the national and state data without age adjustment.

Youth Risk Behavior Survey (YRBS)

Many Healthy Alaskans 2010 indicators are tracked by questions asked in the Youth Risk Behavior Survey (YRBS). Results from the YRBS are intended to help detect changes in youth risk behaviors over time. The results can identify differences among ages, grades, and gender. Alaska first implemented its YRBS in 1995 using all school districts within the State. A second YRBS was conducted in 1999 and included all school district with the notable exception of the Anchorage school district. The shown prevalence percents are the best available estimate of risk behaviors in the school age population.

High school (grades 9 – 12) results are weighted and provide estimates of the prevalence of risk behaviors in students enrolled in eligible schools. Eligible schools are those outside the Anchorage school district excluding correspondence, home study, alternative, and correctional schools. Also, youth who dropped out of school are not included.

Middle school (grades 7 and 8) results are not weighted to the general student population because of a low overall participation rate. However, these results are useful in determining the prevalence of risk behaviors in a large number of Alaska's seventh and eighth grade students in 1999 and will give users insight into the needs and behaviors of students in this age group.

Age adjusting the YRBS rates is unnecessary because Alaska's high school students are generally the same age as students in other parts of the Nation.

Vital Statistics Cause of Death Coding

Causes of death are classified by the Tenth Revision International Classification of Disease (ICD-10). The Tenth Revision replaced the Ninth Revision (ICD-9) that had been in use for 20 years in 1999. The change from ICD-9 to ICD-10 results in discontinuities between selected causes of death by introducing new causes of death titles and their corresponding cause of death codes.

Caution is necessary in comparing mortality rates before 1999 with current rates. Nationally, only 7 of the 15 leading causes of death titles using ICD-9 remain the same under ICD-10 coding. The break in comparability results from changes in category titles, changes in structure and content of the classification, and from changes in the coding rules used to select the underlying cause of death. Mortality statistics are generally based on underlying cause of death, which is defined as "the disease or injury which initiated the train of morbid events leading directly to death, or the circumstances of the accident or violence which produced the fatal injury." The process for identifying the leading causes of death is published in the NCHS Instruction Manual, Part 9, ICD-10 Cause of Death Lists for Tabulating Mortality Statistics, Effective 1999.

Ratios of comparability between ICD-9 and ICD-10 have been studied by the dual classification of mortality records at the national level. A comparability ratio of 1.00 indicates that the same number of deaths was

assigned to a particular cause or combination of causes whether ICD-9 or ICD-10 was used. This does not necessarily indicate that the cause was unaffected by changes in classification and coding procedures but merely that there was no net change in the number assigned. A ratio less than 1.00 indicates that fewer deaths are assigned to the cause of death under ICD-10 than with ICD-9. A ratio greater than 1.00 results from an increase in deaths assigned to a cause in ICD-10 compared with the comparable ICD-9 cause. Technical reports for the National Vital Statistics system are available at www.cdc.gov/nchs/products/pubs/pubd/nvsr/nvsr.htm. The National Vital Statistics Report Volume 49, No. 2, May 18, 2001 (Comparability of Cause of Death Between ICD–9 and ICD–10: Preliminary Estimates) provided an initial estimate of comparability.

The change to ICD-10 increases the number of deaths attributed to Alzheimer's Disease, septicemia, unintentional injuries, Sudden Infant Death Syndrome (SIDS), and several other common causes of death. The number of deaths attributed to heart disease, asthma, pneumonia, and congenital anomalies decreases under ICD-10.

Whenever possible, *Healthy Alaskans 2010* uses 1999 mortality rates to set baselines. Since the 1999 rates are coded with ICD-10, changes can be tracked across the decade.

Issues of small numbers

Many health indicators for Alaska are based on a small number of events. The 15 leading causes of death in Alaska in 1998, for example, included seven deaths from hypertension, 11 from atherosclerosis, and 12 from kidney disease. When health events are sub-divided by borough/census area, race, sex, or age, the number that results lacks statistical significance and may inadvertently identify an individual.

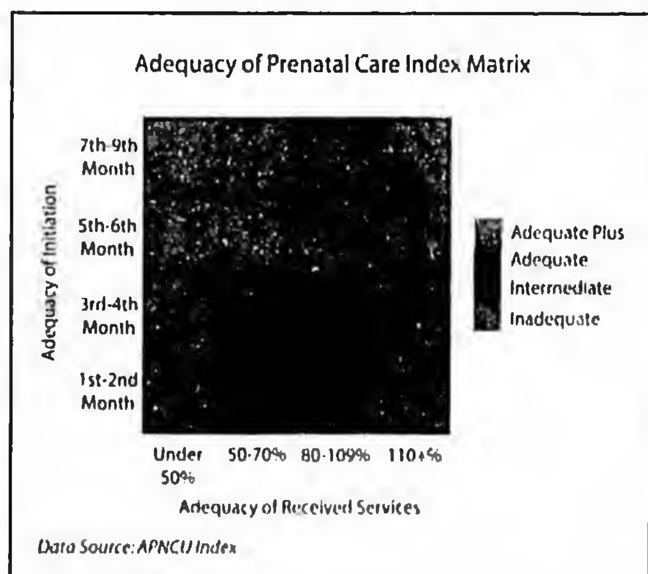
Confidentiality issues are likely to arise with small denominators, small numerators, or rare events. Confidentiality is protected by withholding events with counts less than four, or by aggregating data over time or over larger geographical areas to produce a larger cell size.

Concerns about the reliability and stability of the data arise with small numerators that represent rare or infrequent events. Twenty events is the usual threshold for reliability for estimating age adjusted rates. Rates based on fewer than 20 events have relative standard errors of 23 percent or more. Throughout *Healthy Alaskans 2010* we have attempted to increase numerator size by combining multiple years of data, collapsing data categories, and/or expanding the geographic area under consideration. When rates are calculated for numerators less than 20, a footnote is added: "Rates calculated from < 20 cases may be unreliable." Rates are not calculated for counts under five.

Measuring Prenatal Care: The Adequacy of Prenatal Care Utilization (APNCU) Index

The APNCU index, also called the Kotelchuck Index, uses two crucial elements obtained from birth certificate data—when prenatal care began (initiation) and the number of prenatal visits from when prenatal care began until delivery (received services). The APNCU index classifies the adequacy of initiation as follows: pregnancy months 1 and 2, months 3 and 4, months 5 and 6, and months 7 to 9. To classify the adequacy of received services, the number of prenatal visits is compared to the expected number of visits for the period between when care began and the delivery date. The expected number of visits is based on the American College of Obstetricians and Gynecologists prenatal care standards for uncomplicated pregnancies and is adjusted for the gestational when care began and for the gestational age at delivery.

A ratio of observed to expected visits is calculated and grouped into four categories—Inadequate (received less than 50% of expected visits), Intermediate (50%-79%), Adequate (80%-109%), and Adequate Plus (110%). The final APNCU index measure combines these two dimensions into a single summary score. The chart below summarizes the two dimensions of



Data Source: APNCU Index

Healthy Alaskans 2010 defines adequate prenatal care as a score of 80% or greater on the APNCU Index, or the sum of the Adequate and Adequate Plus categories.

The APNCU Index does not measure the quality of prenatal care. It also depends on the accuracy of the patient or health care provider's recall of the timing of the first visit and the number of subsequent visits. The APNCU Index uses recommendations for low-risk pregnancies, and may not measure the adequacy of care for high-risk women. The APNCU Index is preferable to other indices because it includes a category for women who receive more than the recommended amount of care (adequate plus, or intensive utilization).

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Explanation of the Bridge Series for Census 2000 Comparable Race Categories to 1990 Major Groups

Excerpted and adapted from Greg Williams, Race and Ethnicity in Alaska, Alaska Economic Trends, October 2001

The Census Bureau followed the guidelines of the U.S. Office of Management and Budget (OMB) in conducting the 2000 census. All race and ethnicity was self-reported by the respondent and represented each individual's interpretation of the choices presented. In addition to the race and ethnic categories recognized by OMB, the census allowed people to define themselves as "some other race" and to write in their race. The Census Bureau has so far provided race and ethnicity tabulations in the following forms for 2000 data:

1. One race alone or two or more races.
2. Race alone or in combination.
3. 63 race categories.

A National Academy of Sciences panel studied a series of possible ways to combine the 2000 race data to produce race data comparable to the 1990 and earlier definitions of race. These tabulations are referred to as "bridge" estimates, because they allow comparison of two sets of incompatible data. Of the possible ways of combining the new race data to create tabulations that are comparable to earlier data, the method easiest to understand is what is generally referred to as the "equal proportion or equal fractions." The principle of "equal proportion" involves weighting the multi-race responses on the assumption that they are equal shares of each race. For example, the category of "Alaska Native and White" would be weighted 0.5 Alaska Native and 0.5 White. After all the multi-races are proportionately weighted, the race fractions are summed and rounded to the nearest whole person to obtain the estimated number of persons equivalent to the single race responses of earlier censuses. This procedure has been used at the "place" level (small geographic areas) so that the aggregate figures for census areas or boroughs, or the state as a whole, will be consistent with the place-specific figures.

Visit the Healthy Alaskans 2010 web site at:

www.hss.state.ak.us/dph/deu/projects/healthy/healthy.html

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1/24/01

Alaska Travel Industry Association
FY01 Marketing Implementation Plan

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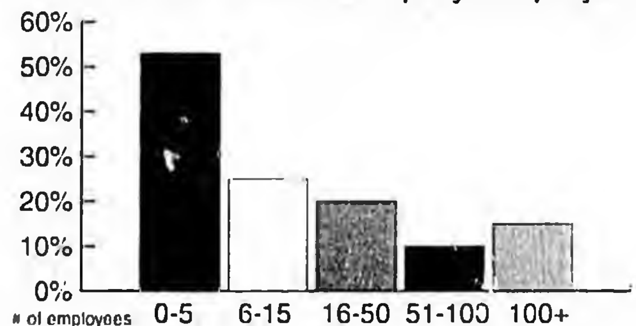
ATIA Overview

The Alaska Travel Industry Association (ATIA) is the new member-based visitor industry trade association for Alaska. ATIA is the result of an industry-led initiative to regain Alaska's competitive position as a visitor destination and to consolidate Alaska's statewide tourism organizations – the Alaska Tourism Marketing Council (ATMC), the Alaska Visitors Association (AVA), and the marketing functions of the Alaska Division of Tourism (DoT) – into one new, non-profit organization. This streamlined structure is the industry's solution to several issues facing Alaska tourism: greatly reduced government funding, continued threats of industry taxes, increased competition from other destinations, and a decline in the rate of visitor growth. Without this renewed effort to regain our position in the marketplace, the Alaska visitor industry is likely to continue to experience a decrease in the rate of visitor growth. The Alaska Travel Industry Association FY01 Marketing Plan will be conducted under contract to the State of Alaska, Department of Community and Economic Development. It is the result of collaboration between visitor industry businesses throughout Alaska and is a blueprint for the beginning of new marketing programs for the industry. This marketing plan includes elements implemented in the past by the ATMC, AVA and DoT, as well as exciting and new initiatives developed by the ATIA members and board of directors.

ATIA's Membership

ATIA's members come from every part of the visitor industry including small bed and breakfasts, charter companies, gift shops, hotels, guiding companies, lodges, cruise lines, destination marketing organizations (DMOs) and tourism support companies. These members have been involved in ATIA's development from the beginning. Through public meetings, forums and committee work, ATIA's membership has been active in the process of shaping and molding how the industry will promote the state of Alaska as a visitor destination.

ATIA Charter Membership by Employment



Board of Directors

The 17 founding members of ATIA's board of directors were elected by the membership in August 1999 to serve terms varying from one to three years. In addition, 6 directors were appointed by the elected directors to serve a one-year term.

The 1999-2000 Board of Directors — Term Expires

Officers

Ann Campbell, Chair: Aurora Consulting 2000

Bill Pedlar, Vice Chair: Pedlar Management Consulting 2000

Susan Woodward Springer, Secretary/Treasurer: Herring Bay Mercantile 2001

Bob Dindinger, Chair of Marketing: Alaska Travel Adventures 2001

Brett Carlson, Chair of Government Relations: Northern Alaska Tour Company 2002

Tina Lindgren, President & COO

Directors

Dale Anderson: Admiralty Tours 2000

Denise Belkoski: Anchorage Convention & Visitors Bureau 2000

Johne Binkley: Alaska Riverboat Discovery/El Dorado Gold Mine 2002

Greg Champion: Sheraton Anchorage Hotel 2000

Ken Dole: Waterfall Resort/Seaborne Aviation 2002

Tom Dow: Princess Cruises and Tours 2000

Bob Engelbrecht: NorthStar Trekking 2001

Pam Foreman: Kodiak Island Convention & Visitors Bureau 2001

Dale Fox: Chenega Corporation 2000

John Fox: Royal Caribbean Cruise Lines 2000

Kirk Hoessle: Alaska Wildland Adventures 2002

Alan LeMaster: Gakona Junction Village 2000

Steve Mahay: Mahay's Riverboat Service 2000

Gary Odle: Alaska Highway Cruises 2002

Ed Peebles: Warbelow's Air 2000

Frank Rose: Alaska Lodging Management 2001

Tom Tougas: Kenai Fjords Tours 2002

Brad Walker: Alaska Airlines 2001

Vision Statement

It is important for an organization such as the ATIA to determine the path it will travel into the future. This has been a prim consideration for ATIA as it takes over the role of marketing the state - - a role formerly held by three separate agencies. The ATIA Board of Directors developed the following vision statement for the organization:

"The ATIA will be the leading industry organization promoting Alaska as a top visitor destination, communicating and promoting the Alaskan tourism industry as one of the state's major economic forces, and will be the respected voice of the industry for the growth of the industry, while remaining attentive to care for the environment, recognition of cultures, and Alaska's unique quality of life."

Mission

As we strive to attain our vision for the Alaska visitor industry, ATIA will undertake the following.

- To promote and facilitate travel to and throughout the state of Alaska.
- To provide a broad-based association of individuals and companies with an interest in the visitor industry in Alaska.
- To encourage the increase and improvement of quality visitor facilities, services, and attractions throughout the state.
- To plan and execute an international marketing campaign promoting Alaska as a visitor destination.
- To increase the awareness of the economic importance of the visitor industry.
- To develop and implement programs beneficial to the travel supplier and consumer, programs that no other sing industry component or organization would be expected t carry out on its own.
- To initiate and cooperate with local, state and federal entities in developing and implementing programs, policie and legislation that are responsive to the needs of the industry and to intervene in those issues and initiatives that would directly affect the facilitation and promotion of travel to and within Alaska.
- To work cooperatively with the state on tourism development and long-range planning.

Principles

These fundamental principles have been established to provide direction for the first year of the organization's existence. They will be a guide for the activities of the board of directors, staff and members of the ATIA.

- ATIA programs will be economically beneficial and effective for a wide spectrum of member businesses.
- ATIA will work to create a healthy and friendly economic environment to encourage new enterprises.
- ATIA will be an inclusive and broad-based association and will provide strong and cohesive representation of the visitor industry in Alaska - including small and rural businesses.
- ATIA will provide a unified voice for the tourism industry.
- ATIA will maintain close working relationships with Alaska's destination marketing organizations.
- ATIA will work aggressively to regain Alaska's role as an innovator in the worldwide tourism marketing spectrum.
- ATIA will develop strong partnerships with the non-tourism or indirect tourism-related businesses.
- ATIA will be attentive to the qu ties that tourism success is built upon, such as care for the environment, recognition of cultures, and Alaska's unique quality of life.
- ATIA and its member businesses will work to be seen as responsible proponents of sound resource management and environmental quality.

Goals

As a statewide trade association for Alaska's diverse visitor industry, ATIA has diverse roles to play – marketing Alaska as a visitor destination, providing member and community relations, providing leadership on visitor industry policy development and advocacy, providing visitor industry education, and planning for the long-term health of the industry and the association.

Obviously, marketing Alaska as a visitor destination is a primary responsibility of the association. This involves bringing Alaska's message to the marketplace when customers are most receptive. To accomplish this, ATIA will target marketing where dollars go the farthest, provide travelers with planning information, maintain a program that has proven results, be an innovator and market leader for destination marketing and market Alaska year-round. The ATIA will also develop multiple marketing messages tailored to different consumer groups and develop effective marketing partnership programs.

Equally important will be our relationship with our members and with Alaska's communities. ATIA will strive to maintain strong member relations by making membership affordable and equitable and by ensuring good communications with membership. ATIA will also strive to maintain strong community relations by communicating the contributions of the visitor industry to Alaska's economy and communities and working to ensure positive impacts on the quality of life of Alaskan residents.

Marketing Committee

Overall, it is the responsibility of the ATIA marketing program to reach out to the marketplace and communicate with a diverse mix of potential visitors. To accomplish this task, ATIA will assume many of the marketing roles previously undertaken by the Alaska Tourism Marketing Council, the Alaska Visitors Association, and Alaska Division of Tourism. Within ATIA, there will be three major program areas. The board of directors will set overall policy and budget, overseeing the Tourism Industry Services, Administration and Marketing functions. The marketing program will be implemented by a professional staff at the direction of the Alaska Travel Industry Association board of directors and its marketing committee.

The marketing committee of ATIA is appointed by the board of directors and is charged with the responsibility of developing the annual marketing plan, as well as supervising the plan's implementation. The development of the marketing plan for FY01 was addressed by the following 27 representatives, selected by the board of directors, from around the state participating as members of the marketing committee.

Additionally, to ensure even greater membership participa- tion, the marketing committee established several advisor committees to work on specific areas of the plan. A list o participants in these committees is included at the conclusion of this plan. The advisory committees for the development of the marketing plan for FY01 included:

- Strategic Planning Committee
- Advertising Committee
- Collateral Committee
- Research Committee
- Internet Committee
- Public Relations Committee
- Trade and International Committee

Marketing Committee Members

1. Bob Dindinger, Chair
2. Ann Campbell
3. Brad Phillips
4. Pierre Germain
5. Gary Odle
6. Kirk Hoessle
7. Jerre Fuqua
8. Ron Peck
9. Susan Woodward Springer
10. Pam Foreman
11. John Mazor
12. Denise Belkoski
13. Dennis Brandon
14. Bob Engelbrecht
15. Charlie Ball
16. Laurie Herman
17. Len Laurance
18. Bill Pedlar
19. Mary Novak-Beatt
20. Wanetta Ayers
21. Sheri Gerhard
22. Brett Carlson
23. Patti Mackey
24. Dale Fox
25. Brad Walker
26. Deb Hickok
27. Tina Lindgren

1-22-2002

Department of Revenue Performance Measures

Submitted to the Alaska Legislature
January 2002
Wilson L. Condon, Commissioner

Listed in order as per SCS CSHB 250(FIN) of the 2001 session

CHILD SUPPORT ENFORCEMENT DIVISION

➢ **Total operating budget as compared to the total amount of collections.**

Target and Progress:

- Fiscal 2001 cost effectiveness was $5.04 collected for every $1 spent in operating funds vs. $5.10 in collections per $1 in operating expenses in Fiscal 2000.
- Although collections increased dramatically in Fiscal 2001 (from $85.4 million in Fiscal 2000 to almost $91 million in Fiscal 2001), the cost-effectiveness ratio went down slightly because of increased costs associated with reducing agency backlogs.

Strategies to Improve Performance:

- Automate agency processes to locate noncustodial parents.
- Increase the use of computerized information to automate enforcement actions.
- Utilize automated financial data matches to increase collections.

➢ **The percentage of current child support collected.**

Target and Progress:

- As of Sept. 30, 2001, the percentage of current child support collected is 51.2%. (*This measure is new for 2001.*)

Benchmark Comparisons:

- Per the Federal Office of Child Support Enforcement Preliminary Data Report for Federal Fiscal Year 2000, the national rate for this measure was 56%.

Strategies to Improve Performance:

- Increase contact with paying parents to ensure orders are set at accurate amounts.
- Increase outreach to parents for order modifications and vacating default orders.
- Increase the number of interstate cases with direct withholding.
- Increase the number of employers reporting new hires to the agency.

- **The number of child support administrative orders and order modifications that are appealed compared to the total number of new administrative orders and modifications issued during the year.**
  Target and Progress:
  - The number of administrative orders and order modifications appealed in Fiscal 2001 was 13%. *(This is a new measure for 2001.)*

  Benchmark Comparisons:
  - Data is not normally reported, making comparisons with other states and entities difficult.

  Strategies to Improve Performance:
  - Maintain quality assurance programs in establishment and modifications in an effort to reduce any errors that could generate appeals.

- **The number of cases where adjustment is overdue by 30 days or more.**
  Target and Progress:
  - At June 30, 2001, the number of cases where adjustments were overdue by 30 days or more was 267. This compares to the more than 3,150 overdue cases on June 30, 2000 and 6,000 in October 1999.

  Strategies to Improve Performance:
  - Continue to reduce backlog numbers in the accounting section by optimizing staff resources to gain efficiencies.

- **The percentage of cases in which there are child support orders.**
  Target and Progress:
  - At September 30, 2001, the number of cases with orders established was 78.0% of total caseload. This compares to 79% on October 31, 2000.

  Benchmark Comparisons:
  - Per the Federal Office of Child Support Enforcement Preliminary Data Report of Federal Fiscal Year 2000, the national rate for the measure was 61%.

  Strategies to Improve Performance:
  - Increase the number of cases without orders that are closed appropriately.
  - Maintain production standards in the establishment section.

- **The number of cases with arrearages that have collections as compared to the total number of cases with arrearages.**
  Target and Progress:
  - At September 30, 2001, the number of cases with arrears that have collections as compared to the total number of cases with arrearages was 68.5%. This is an improvement over last year, when the percentage, as of September 30, 2000, was 64.8%.

  Benchmark Comparisons:
  - Per the Federal Office of Child Support Enforcement Preliminary Data Report for Federal Fiscal Year 1999, the national rate for the measure was 54.4%.

  Strategies to Improve Performance:
  - Continue arrearage collection efforts through third-party contractors.
  - Maintain community outreach program.

ALCOHOLIC BEVERAGE CONTROL BOARD

➢ **The cost of providing compliance services compared to the number of licenses per year.**
Target and Progress:
- Cost of compliance services was $290,500 for 1,825 liquor licenses in Fiscal 2000 (compliance costs of $159 per license).

➢ **The cost of certifying or providing training services compared to the number of servers trained per year.**
Target and Progress:
- Cost of certifying or providing training services was $700 for 6,569 servers trained in Fiscal 2000 ($0.11 per server trained).

➢ **The percentage of noncompliant licenses compared to the number of licenses held per year.**
Target and Progress:
- Of the 1,825 licenses in Alaska, the ABC Board handled compliance problems with about 100 license holders – 5.5%.

ALASKA MUNICIPAL BOND BANK AUTHORITY

➢ **The number of capital projects financed or refinanced with bonds as compared to the total number of projects for which applications were made.**
Target and Progress:
- The Bond Bank received 14 applications in Fiscal Year 2001, 11 of which resulted in 15 projects being financed in 9 communities (vs. four bond issues in Fiscal 2000). The remaining three applications from FY 2001 were funded in the first six months of FY 2002.

Benchmark Comparisons:
- Perform year-to-year trend analysis.

➢ **The par amount of bonds issued during the year and estimated savings to Alaska communities through Bond Bank sales.**
Target and Progress:
- In Fiscal 2001 the Bond Bank issued bonds in a par amount of $50,772,87. Communities are estimated to have saved $3,856,000 through the Bond Bank participating in these financings. This compares to $24.8 million in bonds in Fiscal 2000.

➢ **The cost of operations compared to the value of the bonds issued.**
Target and Progress:
- During Fiscal 2001, the Bond Bank issued $50.7 million in bonds. The total cost of operations for the same period were $0.5 million. Cost of operations represented 1% of the total bonds issued.

ALASKA PERMANENT FUND CORPORATION

- **The corporation's investment expenses compared to the investment expenses of other large institutional funds.**

  Target and Progress:
  - The Permanent Fund has four asset classes that can be evaluated: 1) domestic equities management fees; 2) non-domestic equities management fees; 3) domestic fixed-income management fees; and 4) non-domestic fixed-income management fees.
  - As of June 30, 2001 the asset classes compared as follows: 1) domestic equities fees were lower than 63% of the funds surveyed; 2) non-domestic equities fees were lower than 67% of funds surveyed; domestic fixed-income fees were lower than 90% of funds surveyed; and 4) non-domestic fixed-income management fees were lower than 59% of funds surveyed.

  Benchmark Comparisons:
  - Callan Associates Inc. 1999 Fund Sponsor Cost of Doing Business Survey.

  Background and Strategies:
  - All Alaska Permanent Fund Corporation equities, non-domestic fixed-income securities and a portion of domestic fixed-income securities are managed by external professionals (both active and passive styles). The remainder of domestic fixed-income securities are managed internally. Real estate assets are also managed externally, but investment expenses are netted against income.

- **The total return by asset type compared to other institutional funds.**

  Target and Progress:
  - The Alaska Permanent Fund has five asset classes that can be evaluated for one-year and five-year periods as of June 30, 2001. Total return by asset type compared to other institutional funds. The Permanent Fund Corporation's return will be listed first, then the median return for other institutional funds.
    1) Domestic equities: One year, -13.1% / -5.3%; five years, 13.1% / 14.9%
    2) Non-domestic equities: One year, -22.9% / -23.4%; Five years, 6.0% / 6.0%
    3) Domestic fixed-income: One year, 11.4% / 11.0%; Five years, 7.1% / 7.4%
    4) Non-domestic fixed-income: One year, 0.8% / -6.5%; Five years, no data available
    5) Real estate: One year, 14.3% / 10.2%, Five years, 11.9% / 10.3%

  Benchmark Comparisons:
  - Asset allocation adjusted rankings from the Callan Associates, Inc. Investment Measurement Service.

  Background and Strategies:
  - Comparing returns among similar large investment funds.

- **The inflation-adjusted rate of return over time.**

  Target and Progress:
  - The board has quantified this goal to achieve a real rate of return of 4% over time.
  - The Fund's return for fiscal year 2001 was -3.3%, with inflation of 3.4%. The real (inflation-adjusted) rate of return was -6.7%. The annualized total return for the past 5 years is 9.5%, with a 5-year annualized CPI rate of 2.5%. The real (inflation-adjusted) average rate of return is 7.0% for the past 5 years.

  Benchmark Comparisons:
  - Total Fund return less national CPI.

ALASKA HOUSING FINANCE CORPORATION

- **The administrative costs per dollar of investment.**

  Target and Progress:
  - Fiscal 2001: 4.77% (Operating Expenses/Mortgage Purchases)
  - Fiscal 2000: 5.82% (Operating Expenses/Mortgage Purchases)
  - Fiscal 1999: 5.21% (Operating Expenses/Mortgage Purchases)
  - Fiscal 1998: 7.65% (Operating Expenses/Mortgage Purchases)

  Benchmark Comparisons:
  - AHFC uses the prior year's total actual operating expenses divided by the mortgages purchased for the fiscal year as its benchmark. Total actual expenses include corporate, federal and CIP receipts in all AHFC programs.

- **The net income of the corporation.**

  Target and Progress:

  Fiscal 2001 Net Income: $96,353,000
  Fiscal 2000 Net Income: $81,802,000
  Fiscal 1999 Net Income: $79,350,000
  Fiscal 1998 Net Income: $95,916,000

  Benchmark Comparisons:

  AHFC uses the prior year's net income for the fiscal year as its benchmark. Total net income includes corporate, federal and CIP income of all AHFC programs.

- **The percentage of AHFC-owned housing compared to privately owned housing in the marketplace.**

  Target and Progress:
  - Fiscal 2001 Market Share: 48.6%
  - Fiscal 2000 Market Share: 43.0%
  - Fiscal 1999 Market Share: 33.0%
  - Fiscal 1998 Market Share: 30.0%

  Benchmark Comparisons:
  - AHFC is using the prior year's market share for the fiscal year as its benchmark. The market share is calculated by dividing AHFC's loan purchases by Alaska's total mortgage loans made within the fiscal year.

- **The public housing management assessment score.**

  Target and Progress:

Fiscal 2001 PHAS Score:	Waiting federal action.
Fiscal 2000 PHAS Score:	100%
Fiscal 1999 PHMAP Score:	100%
Fiscal 1998 PHMAP Score:	100%
Fiscal 1997 PHMAP Score:	100%
Fiscal 1996 PHMAP Score:	100%

  Benchmark Comparisons:

  AHFC uses HUD's Public Housing Assessment System (PHAS) rating as its benchmark. Fiscal 2000 is the first year of the new system of third-party assessors. The former PHMAP system was calculated by the Public Housing Authorities and verified by the local HUD office.

TREASURY DIVISION

- **Investment returns against performance benchmarks.**

  Target and Progress:

  Annual returns for the most recent fiscal year are provided below.

Fund // Fiscal 2001 5-year actual return // Fiscal 2001 5-year benchmark return

- General Fund and Other Non-Segregated Investments // 6.34% // 6.25%
- CBRF (main account) // 7.35% // 6.50%
- Alaska Children's Trust // 11.26% // 10.54%
- Public School Trust Fund // 11.85% // 10.54%
- International Airports Revenue Fund // 6.45% // 6.09%

Fund // Fiscal 2001 1-year actual return // Fiscal 2001 1-year benchmark return

- International Airports Construction Funds // 9.20% // 8.81%
- CBRF (subaccount) // (6.01%) // (5.57%)
- RHIF/Long-term Care Fund // (5.60%) // (7.25%)

Fund // Fiscal 2001 3-year actual return // Fiscal 2001 3-year benchmark return

- RHIF/Major Medical Fund // 6.11% // 5.80%

Benchmark Comparisons:

The benchmark return for each fund depends upon its asset allocation -- the mix of different asset classes that Treasury has invested it in.

- Short-Term Fixed-income Investment Pool – 3-month US Treasury Bill
- Intermediate-Term, Fixed-Income Investment Pool - Merrill Lynch 1- to 5-year Government Index
- Long-Term Fixed-Income Pool - Lehman Brothers Aggregate Index
- Domestic Equity Common Trust - Russell 3000 Index
- International Equity Common Trust - Morgan Stanley Capital International Europe, Australia and Far East Index (EAFE)

- **Administrative costs per dollar of investment.**

  Target and Progress:
  - The Treasury Division participated in a national Defined Benefit Pension Fund Survey (of 250 public and private funds) regarding calendar year 2000 costs (performed by Cost Effectiveness Measurement Inc.).
  - ASPIB's 2000 operating costs were 32 basis points, vs. the U.S. average of 35 basis points. The benchmark (which can be thought of, generally, as the average cost for a fund of ASPIB's size and asset mix) was 28 basis points.

  Benchmark Comparisons:
  - ASPIB will continue to participate in this annual survey. Year-to-year trends will also be evaluated, as we would expect our per-dollar of investment cost to decrease as the asset size grows.

  Background and Strategies:
  - Results of this survey need to be interpreted cautiously. Comparing our costs to the overall average may be misleading because costs per dollar of investment is mostly a function of the size of the assets, and this survey had approximately one-third of the participants with plan sizes under $2 billion and the remaining two-thirds of the participants with plan sizes over $2 billion.
  - With a benchmark of 28 basis points compared to an actual cost of 32 basis points, we would be considered a low-cost provider. While this calculation compares like-sized funds, it does not account for differences caused by asset allocation and passive vs. active management decisions.

ALASKA STATE PENSION INVESTMENT BOARD

- **Investment returns expressed in terms of most recent five-year and one-year averages measured against performance benchmarks.**

  Target and Progress:

  The following returns are for the five-year period ending June 30, 2000.

  Fund // Fiscal 2000 5-year actual return // Fiscal 2000 5-year benchmark return
  - Public Employees Retirement Trust Fund // 13.43% // 13.23%
  - Teachers Retirement Trust Fund // 13.61% // 13.23%
  - Military Retirement Trust Fund // 10.30% // 11.17%

  The following returns are for the 3-year period ended June 30, 2000:
  - Judicial Retirement Trust Fund // 10.51% // 11.32%

  Benchmark Comparisons:

  The benchmark return for each fund depends upon its asset allocation.
  - Domestic Equity - Russell 2000 Stock Index or the S&P 500 Stock Index
  - International Equity - Morgan Stanley Capital International Europe, Australia and Far East Stock Index (EAFE)
  - Domestic Fixed Income - Lehman Brothers Aggregate Bond Index
  - International Fixed Income - Non-US Government Bond Index

- **Administrative costs per dollar of investment.**

Target and Progress:

- The Treasury Division participated in a national Defined Benefit Pension Fund Survey regarding calendar year 2000 costs (performed by Cost Effectiveness Measurement Inc.). The universe included 250 plans from Canada and the United States, representing public and private funds. Total U.S. assets represented in the survey were $1,868 billion.
- ASPIB's 2000 total operating costs were 32 basis points, compared to the U.S. average cost of 35 basis points. The benchmark cost (which can be thought of, generally, as the average cost for a fund of ASPIB's size and asset mix) was 28 basis points.

Benchmark Comparisons:

- These results above compare to benchmarks established by Cost Effectiveness Measurement Inc. ASPIB will continue to participate in this annual survey while looking for others to participate in as well. Year-to-year trends will also be evaluated as we would expect our per dollar of investment cost to decrease as the asset size grows.

Background and Strategies:

- The results of this survey need to be interpreted cautiously. Comparing our costs to the overall average may be misleading because costs per dollar of investment is mostly a function of the size of the assets and this survey had approximately one-third of the participants with plan sizes under $2 billion and the remaining two-thirds of the participants with plan sizes over $2 billion.
- With a benchmark cost of 28 basis points compared to an actual cost of 32 basis points, we would be considered a low-cost provider (as opposed to a high or normal cost provider). While this calculation compares like-sized funds, it does not account for differences that are caused by asset allocation and passive versus active management decisions.

TAX DIVISION

- **The division budget as compared to the total amount collected by the division.**

Benchmark Comparisons:

- Division budget (Fiscal 2001) $6.7 million
- Division collections (Fiscal 2001): $1,344.4 million
- Cost of collections vs. total collections: 0.5%

  This compares very well with a "benchmark rule of thumb" of tax collection costing 1% of collected revenues.

- **Percentage of taxes collected as compared to the percentage of taxes due.**
  Benchmark Comparisons:
  - Division collections: $1,344.4 million
  - Division assessments: $1,355.6 million
  - Comparison: 99.2%

- **The time expended compared to the time budgeted and the average time taken to complete audits.**
  Benchmark Comparisons:
  - Actual audit hours 17,432
  - Estimated/budgeted audit hours 19,335
  - Comparison: 90.2%

- **The amount of assessments disallowed on appeal as compared to the amount of assessments claimed.**
  Benchmark Comparisons:
  - Appealed tax and penalty assessments claimed $27.20 million
  - Disallowed tax and penalties: ($2.50) million
    This is negative because the State Assessment Review Board INCREASED the amount of tax in their ruling on an appealed case.

OFFICE OF THE COMMISSIONER

- **The percentage of divisions that meet assigned performance measures.**
  Target and Progress:
  - All divisions are meeting most, if not all, of their assigned performance measures. The commissioner's office will continue tracking the measures and working with those divisions in areas that come up short during the year.

- **The average time taken to respond to complaints and questions that have been elevated to the commissioner's office.**
  Target and Progress:
  - The average time for a written response to dividend complaints and questions addressed to the commissioner's office was 7.7 calendar days in Fiscal 2001. This follows the Fiscal 2000 response time of 6.6 days.
  - The average time for a written response to child support complaints and questions addressed to the commissioner's office was 11.5 calendar days in Fiscal 2001, consistent with the 11.23 days it took in Fiscal 2000.

- **The average time taken to issue decisions in child support and permanent fund dividend appeals.**
  Target and Progress:
  - The average time to issue a child support formal appeal decision is 20 days after the hearing.
  - The average time to issue a dividend formal appeal decision is 30 days.

- **The number of decisions sustained as compared to all decisions appealed to the commissioner's office.**
  Target and Progress:
  - The hearing officer section overturned or amended about 8 percent of the dividend and child support decisions appealed to formal hearing in Fiscal 2001. This compares to just under 10 percent in Fiscal 2000.

ADMINISTRATIVE SERVICES DIVISION

- **The percentage of employee grievances that are overturned by a hearing officer from the Department of Administration or by an arbitrator.**
  Target and Progress:
  - A log is being maintained to track the number of grievances overturned by an arbitrator. Thus far in Fiscal 2002, two grievances have been filed. Neither has been overturned. No grievances were overturned in Fiscal 2001.

- **The percentage of employee complaints and grievances filed at the department level that is resolved at that level.**
  Target and Progress:
  - A log is being kept on grievance filings and their outcome. Thus far in Fiscal 2002, two have been filed and neither has been resolved.

- **The cost of administrative services as compared to total personnel costs for the department.**
  Target and Progress:
  - Total Fiscal 2002 Administrative Services Budget: $1,072,400
  - Total Fiscal 2002 Department Personal Services Budget: $49,063,900
  - For Fiscal 2002, the Administrative Services total budget is 2.20% of total agency personal services.
  - For Fiscal 2001, the Administrative Services total budget was 2.28% of total agency personal services.

- **Number and amount of late penalties assessed for payroll or vendor payment.**
  Target and Progress:
  - A copy of penalty pay documents will be kept on file. No late penalties for payroll have been assessed in Fiscal 2002 or Fiscal 2001.
  - An AKSAS report will be maintained for late penalties. No penalties have been assessed for late vendor payments in FY 2002 or Fiscal 2001.

- **The number of audit exceptions resolved for the department.**
  Target and Progress:
  - A log is being maintained to track the number of audit exceptions or findings resolved for the department.
  - For Fiscal 2001, the department had 7 exceptions/findings and all 7 were resolved.

PERMANENT FUND DIVIDEND DIVISION

➢ **The percentage of dividend payments sent out on time to eligible applicants.**

Target and Progress:

- In Calendar 2001, 95% of applicants (563,491) were paid in the October dividend distribution period vs. 93% (544,940) all eligible in 2000. The division's target for October 2002 is 97%.

Background and Strategies:

- As we gain efficiencies in processing cases held in review, we will be able to increase the number of dividends sent out in the initial distribution.

➢ **The average time taken to process dividend applications.**

Target and Progress:

- The normal processing year begins with the application period in January until we get every application on the mainframe system. The ideal time is five months, to ensure adequate time for review before the distribution period in October. In 2000 we had all applications on the system by mid-April. In 2001 we took slightly longer and had all applications on the system by mid-May.

Background and Strategies:

- The delay in processing for 2001 was due in part to the decrease in the number of temporary employees who stayed through the entire processing season. With the increased use of technology, we hope to replace the need for temporary workers by offering an improved online filing system.

➢ **The average time taken to resolve informal appeals.**

Target and Progress:

- The statutory time limit to complete an appeal from the time it is filed with the division is one year. The division's goal is never to exceed six months. In Fiscal 2001, the average exceeded six months 25% of the time.

Background and Strategies:

- Better screening of applications at the initial step to reduce the number going into review and appeal.
- Improved staff training to separate legitimate cases for review from small errors or questions that can handled quickly.

➢ **The average number of applications in review at the time of the dividend calculation.**

Target and Progress:

- The division continues to experience a large volume of applications that require a higher level of review to determine an applicant's eligibility. In 2001 there were 12,727 applications in review at payment time vs. 8,116 in 2000.

Background and Strategies:

- The division will continue to analyze the criteria that determine whether or not an application needs the higher level evaluation process. In addition, personnel from other units within the division are being cross-trained in order to help with this level of review.

- **The number of application denials upheld on appeal.**

  Target and Progress:
  - In 2001, 1,480 denials were upheld out of 2,064 cases at informal appeal. This amounts to an uphold rate of 71.7%.

  Background and Strategies:
  - Denials are overturned for several reasons. The highest number of denials that are overturned are the result of an error made either on the part of the applicant or within the division when the application was processed. Because of the need to correct errors, the uphold rate will never be 100%.

- **The cost to administer the program compared to the number of applications processed.**

  Target and Progress:
  - In 2001 the cost per application processed was $8.04, vs. $8.08 in 2000.

  Background and Strategies:
  - The cost to administer the program for 2001 was $4,974,200 and the number of applications processed was 618,065. In 2000, the cost was $4,979,700 and the total applications were 616,608. The cost to administer the program has been relatively consistent between fiscal years.

ALASKA MENTAL HEALTH TRUST AUTHORITY

- **The amount of revenue from land and cash.**

  Target and Progress:

	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003
Land Revenue	2,884.0	3,397.6	3,438.9	7,651.0	4,900.0	5,900.0
Cash Revenue	41,869.5	24,606.2	27,645.1	(10,491.3)	10,226.0	23,815.0

  - In Fiscal 2003, the trust projects $15,595.6 available for funding the mental health programs: $11,190.0 in trust investment income (APFC), $2,200.0 in trust land income, $600.0 interest on the Department of Revenue income accounts, $558.2 unobligated MHTAAR from Fiscal 2002, and $1,047.4 from lapsed MHTAAR from FY2001.

- **The percentage of trust income disbursed for mental health programs.**
  Target and Progress:
  - In Fiscal 2002, the trust cash investment at the Alaska Permanent Fund Corporation had an overall market loss of 3.3%, which decreased the disbursement of trust income by 6.5% over the prior fiscal year for mental health programs.
  - In Fiscal 2002, the Trust disbursed $16,627.1 of trust income: 60% for mental health operating, 18% mental health capital, 11% trust land operating and capital, 6% for trust authority administration and 5% for small grants and contracts.
  - In Fiscal 2001, the trust disbursed $17,775.3 of trust income: 59% for mental health operating, 24% mental health capital, 10% trust land operating and capital, 5% for trust authority administration and 2% for small grants and contracts.
  - In Fiscal 2001, the trust increased the disbursement of trust income by 53% over the prior fiscal year for mental health programs.

- **The number of partners and the amount of money from mental health trust programs received from funding partners.**
  Target and Progress:
  - In Fiscal 2002, the trust partnered with 14 different funders, federal agencies and private foundations committed $14 million and the trust will use $497,000 in trust income.
  - In Fiscal 2000, the trust partnered with seven different funders, federal SAMHSA, Federal Transit Authority, AHFC, Fairbanks Borough and City, Petersburg and Alaska Tribal Health Consortium.

	(in thousands of dollars) MHTAAR	Partnering funds
Operating Projects:	$469.0 MHTAAR	$1,141.2 PARTNERING
Capital Projects:	$2,500.0 MHTAAR	$7,550.0 PARTNERING
TOTAL:	$2,969.0 MHTAAR	$8,691.2 PARTNERING

$2.93 match for each $1.00 MHTAAR

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Department of Corrections Missions and Measures FY02 (Chapter 90 SLA 01)	
The mission of the Department of Corrections is to protect the public by confining, supervising, and rehabilitating offenders under the custody of the Department.	
Office of the Commissioner.	The mission of the Office of the Commissioner is to provide support and direction to divisions within the department.
Measure:	The percentage of divisions that meet assigned performance measures.
Data:	100%
Measure:	The number of convicted felons released in a calendar year who return to incarceration after being convicted of a new felony within one year, two years and three years after release.
Data:	Based on data from offenders released in 1997: 76 or 17.67% returned in 1998 40 or 9.3% returned in 1999 and 31 or 7.21% returned in 2000 The percentage for this 3-year period was 34.3. Based on data from offenders released in 1998: 81 or 16.3% returned in 1999 42 or 8.45% returned in 2000 29 or 5.84 returned in 2001 The percentage for this 3-year period was 30.6. According to the 2000 Criminal Justice Institute Adult Corrections Yearbook, the average percentage rate among 39 states was 33.8%. Agencies track the inmates for three years on average following release from prison.
Measure:	The number of days in which the department's facilities are filled at greater than their emergency capacity.
Data:	During FY2001 the Department had a total of 5,475 facility days with 339 days over emergency capacity (6%). In the first six months of FY2002 the Department had a total of 2,760 facility days with 541 days over emergency capacity (20%).
Measure:	The average time taken to respond to complaints and questions that have been elevated to the commissioner's office.
Data:	Response time is currently 8.1 days

Division of Administrative Services

Division of Administrative Services.	The mission of the Division of Administrative Services is to provide support services to departmental programs.
Measure:	The legislature intends to measure the success of the division in achieving its mission by considering the cost of the division compared to personnel costs for the department.
Data:	The total departmental personnel expenditures for FY01 were $89,027,900. The total expenditures for the Division of Administrative Services (Components: Administrative Services, Data and Word Processing, and Facilities) were $4,071,300 or 4.6 % of the Department's personal service expenditures.
Measure:	The number of late penalties incurred for payroll divided by the number of paychecks issued.
Data:	The total number of late payroll penalties incurred during FY2001 was 2 out of approximately 30,000 warrants issued = .00006%
Measure:	The number of late penalties incurred for vendor payments divided by the number of vendor payments issued.
Data:	248 late penalties incurred out of 50,268 vendor payments issued = .005%
Measure:	The number of complaints received concerning payroll errors divided by the number of paychecks issued.
Data:	There were 72 complaints for over 30,000 paychecks issued which equals .0024 percent.
Measure:	The number of outstanding audit exceptions divided by the audit exemptions during the fiscal year.
Data:	State Single Audit for the period ending June 30, 2000 reported no exceptions found for the Department of Corrections. The State Single Audit for Period ending June 30, 2001 is currently in process with an expected completion date of approximately March of 2002.

Division of Institutions

Division of Institutions:	The mission of the Division of Institutions is to ensure that the institutions are maintaining an environment for prisoners that promotes positive change and at the same time fulfills the statutory obligation of protecting the public.
Measure:	The number of inmates assaulted by staff while in custody.
Data:	During FY2001 there were 0 assaults. FY2002 July 1, 2001 through December 31, 2001 0 assaults.
Measure:	The number of inmates assaulted by other inmates while in custody;
Data:	FY2001: 25 FY2002 July 1, 2001 through December 31, 2001: 22
Measure:	The number of inmate suicides.
Data:	FY2001: 4 FY2002 (7/1/01 through 12/31/01): 0
Measure:	The average cost per day per inmate.
Data:	$114.37 per day per inmate.
Electronic Monitoring:	The mission of electronic monitoring is to monitor offenders in the community.
Measure:	The total cost of the program compared to the number of participants.
Data:	During FY01 the Department collected $287,900 in receipts from offenders participating in the program. Total program expenditure for FY01 was $410,400 (all funds). During the fiscal year 405 offenders were placed in the program. This does not reflect cost avoidance by placement on Electronic Monitoring rather than hard or soft bed placement.

FY2001	Offenders Participating	Successfully Completed	Terminated	Active on 6/30/01	Failure Rate
Anchorage	294	192	26	76	8.8%
Fairbanks	103	87	6	10	5.8%
Juneau	8	8	0	0	0

	FY2002 7/1/01 – 12/31/02	Offenders Participating	Successfully Completed	Terminated	Active on 12/31/01	Failure Rate
	Anchorage	132	124	8	55	6%
	Fairbanks	27	24	3	10	11%
	Juneau	3	2	0	1	0%

Inmate Healthcare:	The mission of Inmate Healthcare is to provide essential health care for offenders under the custody of the department.
Measure:	The average medical cost per inmate.
Data:	During FY2001 the medical cost per inmate was $11.10 per day or $4051.50 per year. This is up slightly from FY2000 costs of $10.13 per day or $3697.45.
Measure:	The amount of inmate co-pay fees collected annually.
Data:	During FY2001, $66,157 in co-pay fees was collected.

Inmate Programs:	The mission of inmate programs is to provide opportunities for positive change and to rehabilitate inmates.
Measure:	The number of inmates who complete programs successfully divided by the number of inmates enrolled in the program set out by program. **All statistics below represent July 1, 2001 through December 31, 2001.**
Data:	Batterer's Program - 176 participants. Of the 54 participants no longer in the program, 13 successfully completed (24%), 12 completed their sentence (22%) 19 transferred (35%), and 10 were removed for cause (19%). 122 remain in the programs.
	MCCC Sex Offender Program - 77 participants. Of the 25 participants no longer in the program, 8 successfully completed (32%), 2 completed their sentence (8%), 4 were transferred (16%) and 11 were removed for cause (44%). 52 remain in the program, (*Program is a minimum of 18 months to complete*). 97 assessments were performed.
	LCCC Sex Offender Program – 35 participants. Of the 17 participants no longer in the program, 6 successfully completed (35%), 5 completed their sentence (29%), 3 were transferred (18%), and 3 were removed for cause (18%). 18 remain in the program,
	Adult Basic Education - 331 participants. Of the 126 participants no longer in the program, 54 successfully completed (43%), 29 completed their sentence (23%), 24 were transferred (19%), and 19 were removed for cause (15%). 205 remain in the program.

GED - 683 participants. Of the 285 participants no longer in the program, 130 successfully completed (46%), 36 completed their sentence (13%), 66 were transferred (23%) 53 were removed for cause (18%). 398 remain in program

Youth Offender Program – Since opening in 8/00 there have been 85 participants. To date, 14 have received their High School Diploma, and 4 have received their GED. Of those 85, 14 are program complete, 3 released from custody prior to completion, 3 transferred to sex offender treatment prior to completion, 2 are pending review and 10 have been removed for cause. There are currently 53 in program.

Vocational/Technical:

Apprenticeships – 30 participants. Of the 5 participants no longer in the program, 3 completed (60%) and 2 were transferred (40%) and 25 remain in programs.

Short-term Classes – 155 participants. Of the 118 participants no longer in programs, 82 successfully completed (69%), 5 completed their sentence (4%), 10 were transferred (8%), and 21 (18%) were removed for cause. 38 remain in program.

Traditional Vocational - 387 participants. Of the 126 participants no longer in the programs, 38 successfully completed (30%), 13 completed their sentence (10%), 33 were transferred (26%), and 42 were removed for cause (33%). 261 remain in program.

Substance Abuse Programs (July 1, 2001 through December 31, 2001

Institution	Number Enrolled	Transferred	Released	Removed	Number Completed
HMCC RSAT	85	6	2	5	26
WCC RSAT	69	1	0	10	19
AMCC ISAT*	10	1	1	2	6
LCCC ISAT	42	7	2	4	9
MCCC ISAT	52	6	0	3	7
SCCC ISAT	61	5	0	8	24
WCC ISAT	9	1		0	1
CADC	200	36	0	19	50
Totals	528	63	5	52	141

*There is no current program

Measure: Re-admits who completed inmate programs during previous incarcerations with the department, set out by program. Stats represent FY02, 7/1/01 – 12/31/01.

Data:

Program Previously Completed	# with reconviction
GED	11
Batterer's Program	3
Sex Offender Treatment	1
Hazmat/Hazwopper	1
Building Maintenance Apprenticeship	1
Oilfield Safety	1
ISAT – Outpatient	28

Measure: Inmates enrolled in GED programs divided by the number of inmates who have completed inmate programs.

Data: 683 enrolled in GED
475 inmates have completed inmate programs = 1.43

Correctional Industries: The mission of the Alaska Correctional Industries (ACI) is to assist in the rehabilitation of inmates by providing marketable work skills.

Measure: The percentage of program participants who receive jobs after release.

Data: Between January 1, 2001 and December 31, 2001, , a total of 68 offenders who had worked in ACI while incarcerated were released to the community. Of those 68, 21 are working (31%), 31 are not on supervision and therefore cannot be monitored (46%), 12 are not working (18%) and 4 were re-incarcerated (5%).

Measure: Income divided by expense for each ACI program.

Data:

Program	Income	Expense	Ratio
Fairbanks Garment	$153,034.76	$112,074.04	1.357
Hiland Mtn. Garment	$ 71,169.87	$812,84[illegible].45	.876
Juneau Laundry	$250,426.35	$197,918.79	1.265
Mt. McKinley M&S	$1,405,518.49	$1,405,771.60	1.000
Palmer Auto	$88,103.36	$44,333.82	1.987
Spring Creek Furn.	$469,986.12	$377,688.41	1.244
Wildwood Furn.	$1,289,725.50	$1,260,511.00	1.023
All Programs	$3,726,964.95	$3,659,673.20	1.018

Measure:

(1) the percentage of ACI participants, set out by program, with sentences of:
- (A) less than three years;
- (B) three years to less than seven years;
- (C) seven years to less than 12 years;
- (D) 12 or more years;

	Unsentenced	< 3 yrs.	>3 - < 7 years	>7-<12 years	> 12
Hiland Mountain Garment Shop	23%	41%	8%	13%	15%
Palmer - Autobody Shop & MMK Meats	0	41%	17%	10%	32%
Fairbanks - Garment & Flat Goods shop	30%	51%	16%	2%	1%
Lemon Creek - Private Co-op & Commercial Laundry	6%	23%	30%	15%	26%
Spring Creek Wood Office Furniture	0%	0%	2%	2%	96%
Wildwood - Furniture & Metal Fabrications	1%	37%	32%	17%	13%

Measure:	The percentage of inmate pay that is used to pay restitution.
Data:	The percentage of inmate pay used to pay restitution by ACI workers who made restitution payments during FY2001 was .04%. Restitution is the sixth priority listed in AS 33.32.050. The percentage of inmate pay used to pay child support, which is listed as priority number one, was 30%.
Measure:	The percentage of sentenced inmates who participate in Alaska Correctional Industries.
Data:	During FY2001, 10.3% of sentenced inmates incarcerated in Alaska were participating in Alaska Correctional Industries. From July 1, 2001 through November 30, 2001 an average of 11.1% of sentenced inmates incarcerated in Alaska were participating in ACI.

Division of Community Corrections

Community Corrections:	The mission of the Division of Community Corrections is to develop and maintain public safety through supervision standards in conjunction with the regional chief probation officers; and provide for public safety through supervision of adult felons who are placed in the division's jurisdiction.
Measure:	The number of inmates on felony probation divided by the number of probation officer set out by geographical area.
Data:	July 1, 2001 through December 31, 2001 The Northern Region has 13 probation/parole officers for 1093 supervised (not counting absconders) = 84 average caseload The Southcentral Region has 40 probation/parole officers for 3084 supervised cases (not counting absconders) =77 average caseload The Southeast Region has 6 probation/parole officers for 398 supervised cases (Not counting absconders) 66 average caseload. Caseloads vary, of course, depending on location and whether or not they are specialized caseloads.
Measure:	The number of inmates on felony parole divided by the number of probation officers set out by geographical area.
Data:	The number of probationers and parolees are combined as Probation Officers supervise both and they do not track the distinction.
Measure:	Probationers and parolees arrested, set out by geographical location.
Data:	July 1, 2001 through December 31, 2001

Geographic Area	Offenders supervised	Arrests	Percentage
Northern Region	1093	283	26%
Southcentral Region	3084	396	13%
Southeast Region	398	88	22%

Parole Board

Parole Board:	The mission of the Parole Board is to administer the release of eligible correctional inmates while providing for public safety and for the successful integration of parolees into the community.
Measure:	The change in the number of discretionary parolees who are arrested and returned to custody each year.
Data:	Year 2001 -- 34 Year 2000 – 21 Year 1999 – 23 Year 1998 – 21 Year 1997 – 18
Measure:	The percentage of monitored parolees who are employed each calendar quarter.
Data:	The second quarter of FY 02, there were 759 monitored parolees. 421 were employed (55%), 327 were not employed (43%).

Situational Analysis

The History Of Cooperative Marketing In Alaska

Cooperative Marketing in Alaska really began with the creation of the Alaska Visitors Association (AVA) in 1950. The major emphasis of the association was promotion, including production of the Alaska-Yukon Travel Manuals. In fact, between 1959 and 1970, AVA was known as the Alaska Travel Promotion Association and worked on marketing projects with the Division of Tourism after it was formed in the '60s. In 1976 the first formal cooperative tourism marketing efforts between the state of Alaska and the tourism industry began, when AVA approached the state with an innovative proposal to co-mingle private and state funds to draw visitors to Alaska. The idea was simple: combine funding from the state with money, marketing talent, and knowledge contributed by the private sector to build a program to promote the entire state as a destination. Program recommendations were provided by the Alaska Visitors Association Marketing Council and implemented by the Division of Tourism (DoT).

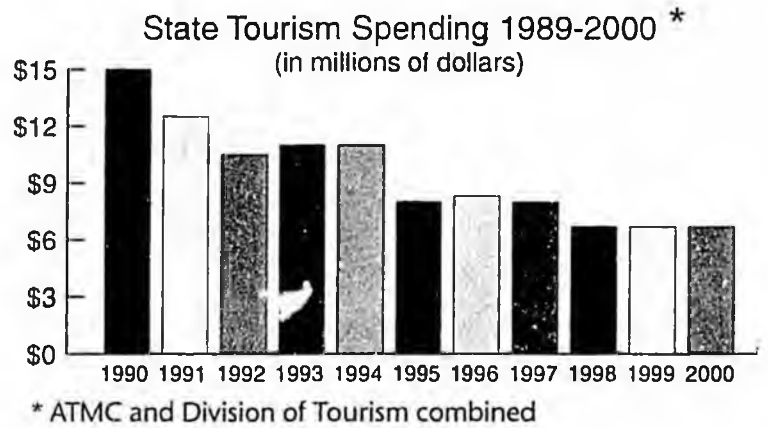
This melding of industry and state tourism efforts went a step further with legislation passed in 1988 to form the Alaska Tourism Marketing Council (ATMC). Jointly managed by the state and AVA, the ATMC oversaw promotion of Alaska to the domestic and Canadian markets, while the State Division of Tourism (DoT) managed the international marketing efforts for Alaska. This unique program created a consistent, high-quality marketing plan that bolstered industry expansion efforts, as evidenced by the phenomenal growth in the number of visitors to the state. For many years, Alaska's sophisticated marketing techniques and public/private structure served as a model for other destinations. The ATIA is an industry-led initiative to continue the strong tradition of cooperative marketing in Alaska -- while addressing the decline in state spending on visitor industry marketing.

Alaska is Losing Ground

Since 1989, state funding for tourism programs has declined nearly 60 percent, from $15 million in FY90 to less than $6.7 million in FY00. At the same time, other states have increased their tourism promotion by 26 percent in the last five years.

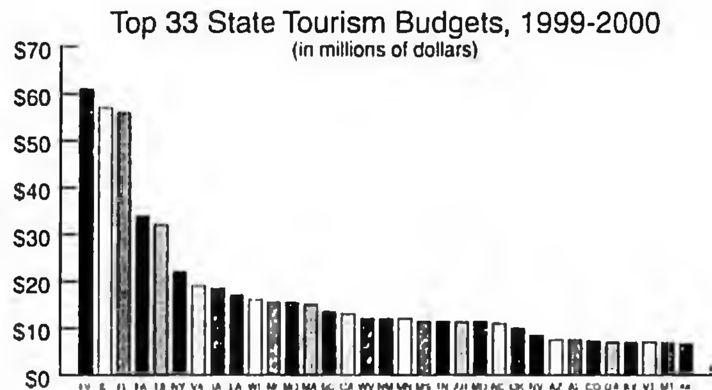
Alaska State Tourism Spending

FY90	$15,029,050
FY91	$12,446,571
FY92	$10,526,171
FY93	$10,933,387
FY94	$10,913,338
FY95	$ 8,038,963
FY96	$ 8,384,047
FY97	$ 7,990,100
FY98	$ 6,728,950
FY99	$ 6,696,950
FY00	$ 6,668,500



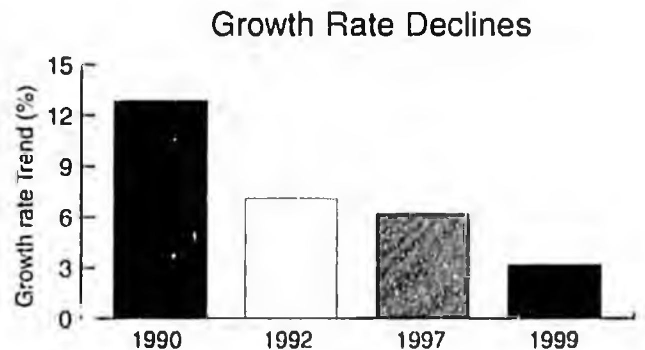
Competition Is Increasing

Alaska is also losing ground due to increasing competition from other states, countries, and new destinations. While Alaska's most direct competitors are foreign countries, we are also being out-spent in promotion by other states and even cities. This lack of advertising dollars has placed the visitor industry at a competitive disadvantage. Alaska continued its trend of decline among the nation's tourism budgets in 1999-2000, slipping four spots from last year to settle at 33rd place. Over the past decade, funding for Alaska tourism programs has declined by 60 percent – dropping Alaska from 7th place to its current ranking.



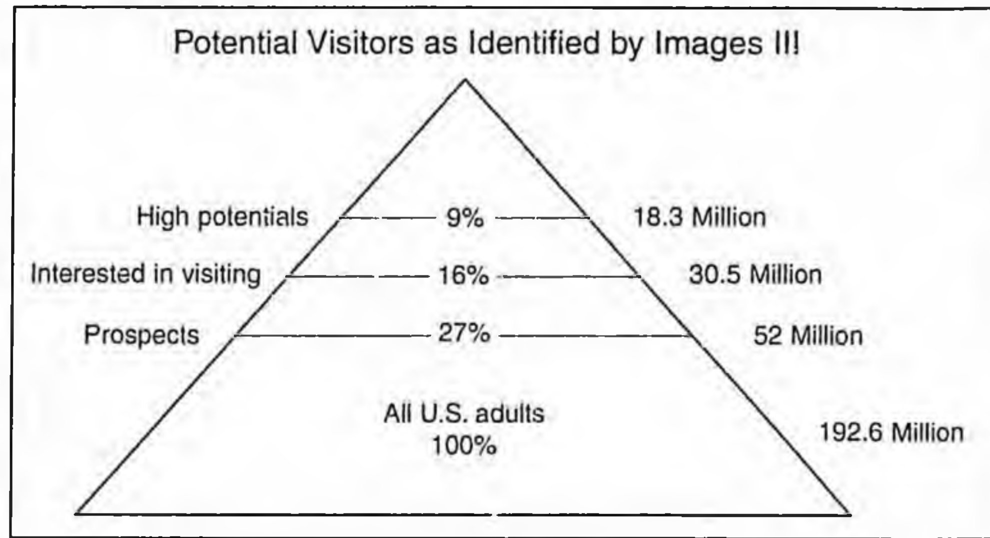
Growth Rate Is Declining

Alaska's relative decline in marketing competitiveness is being felt within the industry. While overall visitor numbers have continued to rise, the rate of growth has slowed. Some segments of the industry, most notably highway-dependent businesses, have felt the first effects of decline.



Alaska's Potential Visitors

Alaska is a unique travel destination. And for many visitors, travel to Alaska is a dream come true. Like any other destination, Alaska has its strengths and weaknesses. According to Images III Study, conducted by the ATMC in 1996, one of Alaska's strengths is the number of potential visitors out there – there are about 18 million U.S. adults with "high potential" to travel to Alaska and 30.5 million U.S. adults "interested in visiting."



Our weakness, though, is that these people believe that travel to Alaska is very costly and the weather is very cold, which are tough perceptions to overcome.

Industry Forum

At visitor industry forums held in Ketchikan, Fairbanks and Anchorage during the fall of 1999, the discussions highlighted the strengths and weaknesses of Alaska as a visitor destination. At each of these forums, the participants identified Alaska's beauty, wildlife, and culture as our strongest attributes and identified the lack of marketing funds, increased competition, and the cost and distance of Alaska travel among our biggest challenges.

Other strengths and weaknesses included:

Strengths	Weaknesses
Natural beauty	Lack of marketing funds
Scenery	Cost and time to travel
Wildlife	Lack of statewide image
Native cultures	Increasing competition
Northern Lights	Maintaining a quality experience
Adventure	Lack of winter infrastructure and packages
Varied cultures	Trip-planning challenges
Year-round opportunities	Lack of infrastructure
Winter sports	Over-crowding in some locations
State and national parks	Severe winter/climate image
Fulfillment of a dream	
Glaciers	
Fishing	

Solutions

Alaska's marketing challenges were brainstormed during each of the visitor industry forums, and participants generally agreed that strong cooperative marketing was critical. Additional strategies and actions identified as important by participants included:

- Strong generic marketing
- Strong overall image campaign
- Strengthen Internet presence
- More cost-efficient ways for small businesses to participate
- Continue strong research efforts
- Cooperative marketing programs for all segments within industry
- Generate qualified, quality leads of potential Alaskan visitors
- More effort to reach repeat visitors
- National television campaign
- Goal-based program with quantifiable performance measures

FY01 Marketing Plan

The goals and objectives for the FY01 Marketing Plan are:

1. **Goal: Maintain or increase the average length of stay in Alaska.**
   Objective: No decrease from 9.8 nights during summer season and 8.2 nights during fall/winter season.

2. **Goal: Increase year-round employment of Alaskans in the visitor industry throughout the state.**
   Objective: Increase visitor-related employment of Alaskans to 30,700 direct and indirect full-year jobs.

3. **Goal: Attract a diverse mixture of visitors who travel to and within Alaska by a variety of travel modes.**
   Objective: Increase travel by all modes.
   Objective: Increase travel to all regions of the state.

4. **Goal: Endeavor to position Alaska as a year-round destination.**
   Objective: Increase fall/winter arrivals by 3%.
   Objective: Increase summer arrivals by 3%.

5. **Goal: Increase total visitor expenditures statewide; endeavor to maintain or increase per-trip expenditures.**
   Objective: Increase visitor expenditures above the current figure of $949 million statewide.
   Objective: No decrease in per-person, per-trip spending from current estimated level of $726.00.

6. **Goal: Increase independent visitation to Alaska.**
   Objective: Define current independent visitation and establish benchmark for future tracking.

7. **Goal: Increase the rate of repeat visitation.**
   Objective: Include repeat visitation in the Alaska Visitor Statistics Program (AVSP) to establish a benchmark.
   Objective: Include repeat visitors in the Images IV study to establish benchmarks.

8. **Goal: Increase interest in Alaska as a visitor destination.**
   Objective: Increase the number of inquiries to all ATIA marketing programs.
   Objective: Complete the Images IV study to establish baseline trends.

9. **Goal: Increase awareness and participation of businesses in the marketing program.**
   Objective: Implement database tracking of total number of businesses who participate in marketing programs.
   Objective: Implement tracking program for participation in individual programs.

10. **Goal: Increase private-sector funding of state tourism marketing programs.**
    Objective: Generate at least 30% of program costs.

Market Strategies

The decision process used by visitors to Alaska begins first with an awareness of Alaska and an interest in travel. For some visitors, an Alaskan vacation is a lifetime dream destination, for others, an Alaskan vacation is a recent ambition. Both however, start in the same place – an interest to travel to Alaska.

Once the interest takes hold, the next step for an Alaskan visitor is the actual decision-making and planning of the trip. This process, again, can range from a lifetime of planning to a quick, recent decision to travel. Potential visitors in this mode are gathering information, thinking about alternatives, and trying to decide if Alaska is "on the vacation list." And then, a decision - "We're going to Alaska."

Now, the planning and information search is really on – visitors in this mode are making itinerary and product choices and require information on the variety of options and activities Alaska has to offer. Visitors come in a wide variety, with a variety of interests – no one option or alternative will work for all potential visitors. Hence, the need to ensure that Alaska and its visitor industry businesses respond to these potential visitors with a wide selection of activities, attractions, and experiences.

Overall, it is the responsibility of the ATIA marketing program to reach out to the marketplace and communicate with potential visitors in each stage of the decision process – from the "interest" stage to the "we're going" stage. And just as the information needs of potential visitors vary at each stage of the decision process, the best way to communicate that information varies at each stage of the decision process. Additionally, it is our responsibility to measure the reach and effectiveness of our marketing efforts; thus, the ATIA marketing program will include a strong market research element.

Image awareness campaigns are the most effective media to communicate with potential visitors who are just developing awareness of their interest in Alaska. The ATIA marketing program has designed a variety of public relations and Internet strategies to reach out and stimulate potential visitors' awareness of Alaska and to spark their interest in traveling to Alaska. ATIA will conduct image and awareness programs targeted both to domestic U.S. consumers and international consumers and will utilize a wide variety of niche and market segments image and information.

Once an interest exists, how do you find those potential visitors and gather enough information from them to determine if their interest is strong enough to convert to an actual "travel to Alaska" decision? The ATIA marketing program has designed an aggressive direct-response program that will reach out and locate over 581,925 potential visitors and motivate them to request actual Alaska trip planning information via mail, toll-free number, or the Internet. The tactics utilized to motivate potential visitors will include a wide variety of niche and market segment images and information, again attempting to appeal to a wide variety of potential visitor interests. In order to send them Alaska trip-planning information, ATIA needs to know their names and addresses – which will then be made available for destination marketing organizations and Alaska visitor businesses to follow-up with specific regional and product information.

In addition, ATIA will be working closely with tour wholesalers and operators, both encouraging them to bring groups to Alaska and ensuring that they have the knowledge and information they need to book group travel throughout Alaska. As with consumer marketing, ATIA's work with the travel trade will include both domestic U.S. and international wholesalers and operators.

Target Audience

The target audience for the ATIA advertising program consists of a primary target audience of 35+ year old couples with no kids, and a secondary target of 35+ year old couples with kids and 35 and under singles with no kids. Over the years, these targets have proven to constitute the majority of Alaska's visitors – they have proven to be the folks with the time and money, as well as interest and motivation to travel to Alaska.

Primary Target Audience

Age: 35+
Employed or Retired
Single or Married
No Children

Secondary Target Audience

Age: 35+, Employed, Married with Children
'Jnder 35, Employed, Single, no Children

The Five Major Components Of ATIA'S Marketing Program

The Board of Directors of the Alaska Travel Industry Association and the State of Alaska, Department of Community and Economic Development established the following major components for the FY01 Marketing Plan:

Consumer Marketing
Niche Marketing
Trade and International Marketing
Inquiry Fulfillment
Market Research

Consumer marketing will include image campaigns and direct-response programs utilizing a variety of media and tactics. Additionally, special programs will be developed to expand consumer marketing efforts into special niche market segments, such as winter activities, cultural tourism, sports fishing, adventure-eco tourism, highway and marine highway segments, and bed & breakfast accommodations.

Trade and international marketing programs will continue important activities previously conducted by the Division of Tourism. These programs will include image awareness, direct response programs, and education and training programs. Additionally, the Alaska Travel Industry Association will continue Alaska's partnership with the Yukon, British Columbia, and Alberta in the cooperative marketing program Tourism North.

Inquiry fulfillment programs will ensure distribution of travel information that will help motivate potential visitors to plan a trip to Alaska and to provide useful trip-planning and product-specific information. Our Inquiry Fulfillment program will strive to provide extensive, factual information on travel to and within Alaska, the variety of activities available for visitors, and trip and itinerary-planning assistance.

And, finally, Market Research will be conducted to measure the effectiveness of ATIA's programs and to learn more about Alaska's visitors and potential visitors.

The Board of Directors and Marketing Committee for ATIA, along with members of advisory committees, destination marketing organizations and members, have developed the following marketing strategies to address the 10 ATIA Marketing Goals and to ensure that the each of the 5 Major Components are significant elements of the program. The following Plan is subject to change based upon fluctuating market conditions, budgetary factors and new information.

The FY01 Marketing Plan will be implemented by the ATIA staff under the supervision of the Project Manager, ATIA President Tina Lindgren, and the general oversight of the ATIA Marketing Committee.

Public Relations

Public relations is a key component to the ATIA marketing program. A positive, visitor-friendly image of Alaska created through feature articles, guidebooks, and television will promote travel to the state. The approach for the public relations effort will be to promote Alaska as a year-round visitor destination. The media will be familiarized with the variety of travel options and modes of transportation. An emphasis will be placed on the uniqueness, beauty, and variety of activities in Alaska not only in the summer, but in the off season as well. The state will be promoted as a whole, highlighting the virtues and diversity of each region.

Strategy 1: Work with the media to generate travel stories that feature a variety of Alaska travel products and regions

Tactics:

- Provide timely story ideas to travel editors at major magazines and newspapers.
- Offer editors and writers timely reminders that ATIA is their first stop for travel information about Alaska, photography, and other assistance.
- Strive to get the toll free number (800-862-5272) and the web site (www.travelalaska.com) placed as a reference sidebar to Alaska editorial.
- Work with the broadcast media, primarily television. in major markets for the purpose of attracting television crews to Alaska to develop feature packages.
- Place well-spoken experts about Alaska's visitor industry on radio call-in programs in target markets.
- Develop a series of Alaska press kits for distribution to key broadcast media outlets and editors in major markets.

Strategy 2: Continue and enhance media center on the ATIA website

Tactics:

- Add new photography, as it becomes available.
- Add new site enhancements and content.
- Develop a more intensive series of links to relevant vendors and destination marketing organizations.

Strategy 3: Assist qualified writers with trip-planning and bring qualified writers to Alaska

Tactics:

- Conduct separate press trips in the winter and summer.
- Provide 5-7 press trip opportunities in conjunction with the World Adventure Congress scheduled in Anchorage in September 2001.
- Attract top-notch writers and editors for individual itineraries.
- Coordinate itineraries, complimentary services, and work with media on story angles, photos, and any other materials to secure maximum coverage.
- Work with destination marketing organizations across the state on media trips, media assistance requests and information requests.

Strategy 4: Continue to include winter and other seasonal promotion as part of the overall public relations effort

Tactics:

- Conduct a winter press trip targeting 12 travel writers or broadcast media and follow-up on story placement.
- Assist Special Olympics organizers with public relations efforts.
- Work with destination marketing organizations and winter operators to conduct targeted winter promotions and contests.
- Develop promotional efforts to draw attention to ice carving and Northern Lights viewing.
- Pitch an ice climbing promotion to outdoor and sports cable channels.

Strategy 5: Feature a variety of market segments and geographical regions in public relations program

Tactics:

- Send out one press release per month about Alaska to feature important events, regions of the state, or a seasonal discussion.
- Send out a minimum of two e-news bulletins each month, using the database that currently contains over 600 e-mail addresses for travel writers and editors. Topic content will focus on seasonal events, regional activities, as well as unique stories about Alaska.
- Solicit input from destination marketing organizations and industry businesses around the state.
- Develop five new stories for publications, featuring new travel trends, new attractions and developing areas of tourism in Alaska.
- Refresh five stories from the story archive.

Strategy 6: Ensure ATIA board is prepared to respond to any travel-related crisis

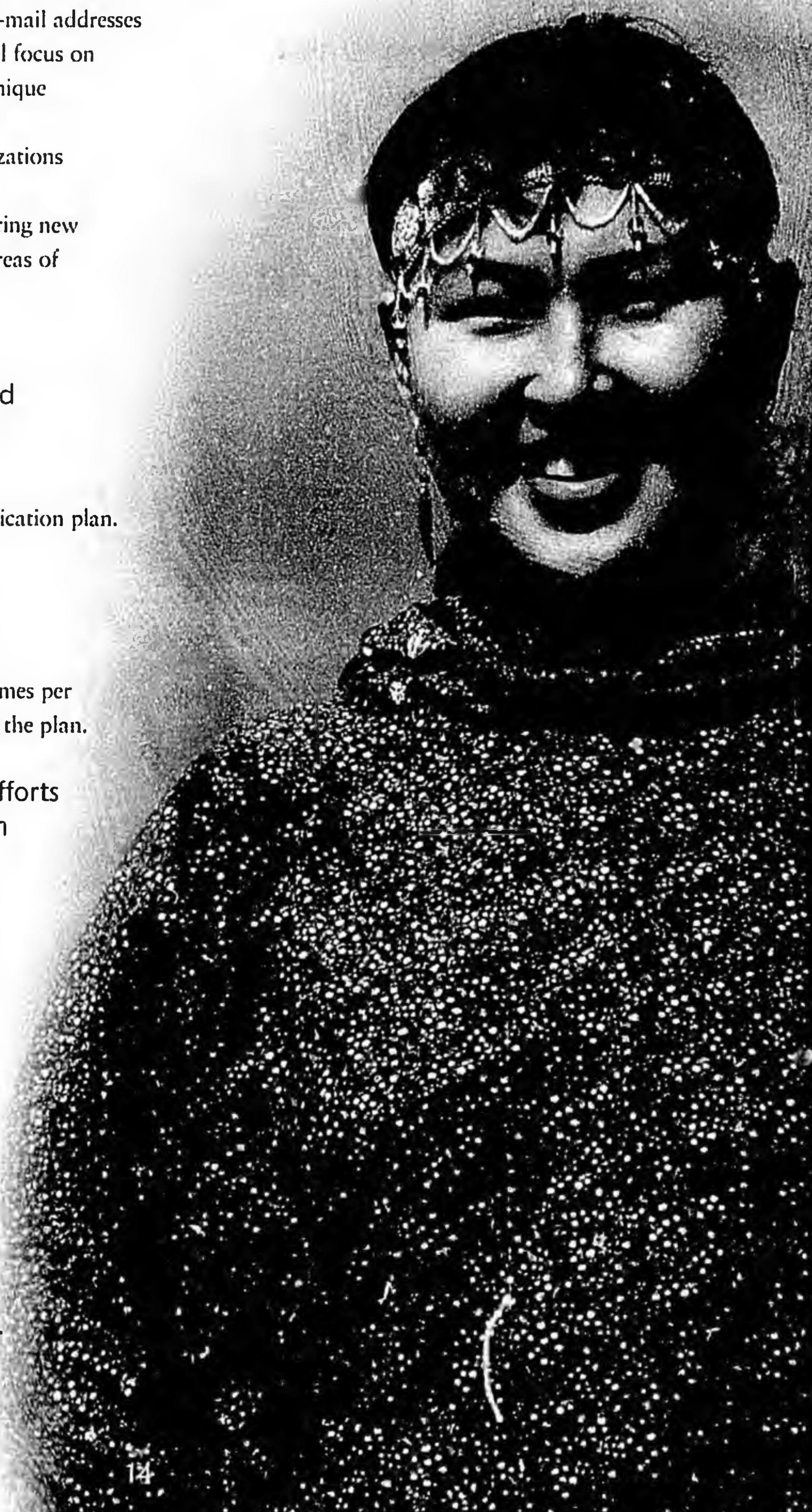
Tactics:

- Update and improve the existing crisis communication plan.
- Work with ATIA staff to determine a core crisis communication team.
- Consider crisis media training as a partnership opportunity for ATIA members.
- Meet with the crisis communication team 2-4 times per year to evaluate and update key components of the plan.

Strategy 7: Coordinate public relations efforts with member businesses and destination marketing organizations

Tactics:

- Identify current public relations efforts within the visitor industry.
- Conduct a public relations conference to exchange and identify possible synergies and means for gaining maximum exposure for all market segments and regions.
- Review opportunities to partner more effectively with Tourism Yukon's public relations efforts, especially regarding winter opportunities.
- Hold monthly teleconference with destination marketing organizations to discuss relevant topics.
- Be proactive in communication with the membership and solicitation of ideas.



Advertising

The role of advertising in the ATIA marketing plan is to help find potential visitors and gather enough information from them to determine if their interest is strong enough to convert to an actual "travel to Alaska" decision. The ATIA marketing program has designed an aggressive direct-response program that will reach out and locate over 581,925 potential visitors and motivate them to request printed Alaska trip planning information -- via mail, toll-free number, or the website. The tactics utilized to motivate potential visitors will include a wide variety of niche and market segment images and information, again attempting to appeal to a wide variety of potential visitor interests.

Based upon annual conversion studies and previous market segmentation research, Alaska has found that the most efficient media for the direct response program consists of direct mail, consumer magazines and selected Internet strategies. Efficiency is a measurement of both the number of potential visitors reached and cost of advertising. For the FY01 ATIA Marketing Implementation Plan, we will rely most heavily upon our direct mail and consumer magazine campaigns to generate the targeted requests for printed Alaska vacation planning information.

Again, based upon annual conversion studies and other Alaska visitor industry research, the placement schedule for the direct response program begins in September 2000 and continues through March 2001, with the exception of the Internet campaign. The Internet campaign will continue through June 2001 to accommodate late season planners.

Vacation Planning Information Request Generation Source

Strategy 1: Execute direct mail program to generate 400,130 requests for printed Alaska vacation planning information from qualified prospects with high conversion potential and low cost-per-response

Tactics:

- Mail to potential visitors who have requested information in prior years.
- Mail to names from purchased lists that have performed in prior years.
- Mail to subscribers of magazines with high Alaska and/or travel content.
- Mail to purchased names meeting target audience and market segments.
- Test e-mail and Internet strategies.

Direct Response Media Schedule												
	2000						2001					
	July	Aug.	Sept.	Oct.	Nov.	Dec	Jan.	Feb.	March	April	May	June
Consumer Magazines			■	■	■	■	■	■				
Direct Mail			■	■	■		■	■				
Internet				■	■	■	■	■	■	■	■	■
Canadian Magazines			■	■	■	■	■	■				

Strategy 2: Execute U.S. consumer magazine advertising program to generate 136,357 requests for printed Alaska vacation planning information from qualified prospects with high conversion potential and low cost-per-response

Tactics:

- Place full-page ads, with Business Reply Cards and Internet web site address, in 38 U.S. consumer magazines.
- 23 magazines will advertise Alaska on reader service cards (Bingo).
- 20 magazines will run link on their web sites to ATIA electronic Business Reply Card

Strategy 3: Execute Internet advertising program to generate 32,045 requests for printed Alaska Vacation planning information from qualified prospects with high conversion potential

Tactic

- Feature ATIA's web site address prominently in all consumer magazine advertising and direct mail materials.
- Place banner ads on Alaska travel content to link potential visitors with ATIA web site.
- Execute opt-in e-mail program to send travel information to addresses of prospects that have requested information.
- Execute e-mail newsletter program.
- Attract qualified leads to ATIA web site with search engine optimization.
- Test new Internet advertising opportunities.

Strategy 4: Execute joint Yukon advertising program to generate requests for qualified prospects with high conversion potential

Tactics:

- Place full-page ads, with Business Reply Cards and Internet Website address, in 3 Canadian consumer magazines in Ontario and Western Canada.
- Place full-page ads with business reply cards and internet website address in up to 5 U.S. consumer magazines geared to highway travel.
- Execute internet marketing.

U.S. and Canadian Advertising Plan by Publication

Publication	September (28, 4, 11, 18)	October (25, 2, 9, 16, 23)	November (30, 6, 13, 20)	December (27, 4, 11, 18, 25)	January (1, 8, 15, 22)	February (29, 5, 12, 19)	March (26, 5, 12, 19)
Outdoor Adventure/Affinity							
Canoe & Kayak Magazine						■	■
National Parks Magazine					■	■	
National Wildlife				■	■		
Outdoor Life						■	
Outdoor Photographer				Alaska Editorial			
Outside						■	
Popular Photography			■				
In-Flight Magazines							
Delta Sky Magazine					■		
Northwest World Traveler	Alaska Editorial						
General Travel							
Arthur Frommer's Budget Travel					■	■	
Travel America	Alaska Editorial	Alaska Editorial					
Travel Holiday			■	■			
Vacations/Travel 50 & Beyond	Alaska Editorial	Alaska Editorial	Alaska Editorial	Alaska Editorial			
Highway Travel							
Arizona Highroads (AAA)			■	■			
Coast to Coast					Alaska Editorial	Alaska Editorial	
Colorado Motorist (AAA)		■					
Home & Away					■	■	
Journey - WA (AAA)	■	■					
Midwest Traveler (AAA)					Alaska Editorial	Alaska Editorial	
Trailer Life		■					
VIA (AAA)			■	■			
Westways (AAA)			■	■			
General Lifestyle							
Alaska Magazine							■
Audubon	■	■					
Coastal Living	Alaska Editorial	Alaska Editorial					
Discover							■
Prevention				■			
Readers Digest		Alaska Editorial					
Yankee		■					
Canadian Magazines							
Chatelaine						■	
Canadian Living						■	
Harrowsmith	■	■					

Note: Many of the publications above Alaska editorial is TBD.

Collateral

The state's collateral program, a program that designs and produces the statewide printed material, will be essential to attracting visitors to Alaska. Even as destination marketing takes a turn towards digital collateral, it will never completely replace the selling power of full-color images and planning brochures. The collateral program will consist of three major components that include The Official Alaska State Vacation Planner, Invitation to Alaska (a 24-page, full-color introduction to Alaska), and specialty brochures to address specific markets.

Strategy 1: Provide printed statewide Alaska image information to interested prospects

Tactics:

- Design and produce 375,000 copies of the Invitation to Alaska.
- Prominently feature ATIA's web site address in Invitation to Alaska.
- Design invitation cover to emphasize Alaska's scenery and beauty.

Strategy 2: Provide printed statewide Alaska travel product information to highly qualified prospects

Tactics:

- Design and produce 450,000 copies of the Official Alaska State Vacation Planner.
- NEW • Design planner cover to emphasize Native culture and the variety of activities available to visitors.
- Refresh and update editorial content.
- NEW • Revise advertising directory to improve usability.
- NEW • Design a destination marketing organization marketing partner page for the back cover of planner.
- NEW • Change inside back of Planner to highlight participating destination marketing partners and provide mechanism for information request.
- NEW • Add destination marketing partner reply card

Strategy 3: Design and produce new specialty brochures for selected market segments.

Tactics:

- NEW • Identify potential market segments for brochure development.
- NEW • Survey marketing partners for interest in participation.
- NEW • Design and produce brochures.

Internet

Internet usage is skyrocketing -- according to a report by the Travel Industry Association of America, the correlation between the online population and travel is so strong that almost all Internet users are also travelers. It is vital that Alaska's visitor industry keeps in line with the progress of technology. Marketing via the Internet also levels the playing field for smaller businesses since establishing a presence on the World Wide Web can be very easy and relatively inexpensive.

The existing Alaska consumer travel website will be greatly expanded to increase the quality and range of information available to potential visitors and to increase the access of Alaska's tourism businesses for a wide range of new customers and markets. "Driving customers to marketing partners' businesses" will become an increasingly important element of the ATIA Internet program. As part of this effort, a significant advertising and promotional campaign will be executed to "drive potential visitors" to the ATIA website; this effort is detailed in the Advertising section of the FY01 Marketing Implementation Plan.

Key elements of the Internet strategy will be small business emphasis, year round content, increased e-commerce opportunities, and content-rich sections for niche market segments such as adventure & eco-tourism, winter, sports-fishing, bed & breakfast and cultural tourism.

Strategy 1: Upgrade existing website content, formatting, and navigation to enhance usability

Tactics:

- Standardize format throughout the consumer site.
- Implement "short-wide" design model to ensure that content, advertisers and marketing partners can be reached easily from all pages of the site.
- Upgrade content to represent the wide spectrum of companies in Alaska's visitor industry.

Strategy 2: Upgrade features to consumer website

Tactics:

- Create "Frequently Asked Questions" section.
- Upgrade the "Trip Planner" section to allow more advanced sorting and planning features.
- Create "Opt-In Newsletter" for consumers.
- Create additional virtual tours.
- Enhance Alaska map to support zooming on regions and hot links.
- Evaluate additional upgrades.

Strategy 3: Integrate existing content from other compatible websites to maximize information and feature availability to consumers

Tactics:

- Integrate content from state and federal agencies, such as National Park Service, Alaska Marine Highway and the National Forest Service.
- Develop cross-linking relationships with marketing partners such as Tourism North and destination marketing organizations.

Strategy 4: Investigate additional marketing partnership opportunities beyond basic listings and links

Tactics:

- Investigate banner ad opportunities at the top of appropriate "inside" pages.
- Investigate enhanced listings that allow descriptive narratives plus links to e-mail and web sites.
- Allow purchase of multiple listings per advertiser.
- Develop lead generation opportunities.
- Develop e-commerce opportunities.

Strategy 5: Expand website to provide portals to marketing partners' product information and websites

Tactics:

- Develop enhanced marketing partner product database.
- Develop enhanced search features for marketing partner product information.
- Investigate e-commerce options.
- Develop benchmarks for measuring effectiveness of site as portal to marketing partners' product.

Inquiry Fulfillment

The role of inquiry fulfillment in the ATIA marketing plan is to provide potential visitors with information that will help motivate them to plan a trip to Alaska and to provide useful trip-planning and product-specific information. Our inquiry fulfillment program will strive to provide extensive, factual information on travel to and within Alaska, the variety of activities available for visitors, and trip and itinerary-planning assistance.

The tactics utilized to provide potential visitors with Alaska printed information will include the distribution of ATIA's printed materials, state of Alaska and regional destination marketing organizations, and other marketing partner materials. Additionally, ATIA will encourage and provide tools to marketing partners, such as destination marketing organizations and visitor industry product industry businesses, to provide product specific information to prospective visitors and travel trade.

What's the difference between the "Invitation to Alaska" and the "Official Alaska State Vacation Planner?"

The "Official Alaska State Vacation Planner" is the brochure that is mailed to potential visitors who request printed information on Alaska and indicate that they will be traveling to the Alaska within the next two years. Also, the "Official Alaska State Vacation Planner" is a combination of image photos and descriptive editorial and of a directory of advertisers representing a wide variety of businesses throughout Alaska.

"Invitation to Alaska" on the other hand, is the brochure that is mailed to prospects who are not certain that they will travel to Alaska or are not certain when they will travel to Alaska. It is primarily an image piece designed to spark their interest in Alaska travel. Unlike the "Official Alaska State Vacation Planner," the "Invitation to Alaska" does not have an advertising directory, but does prominently feature the ATIA web site address.

Strategy 1: Distribute Alaska image and planning information to interested prospects generated through ATIA's marketing programs and other sources

Tactics:

- Distribute Invitation to Alaska to 375,000 interested prospects.
- Distribute Official Alaska State Vacation Planner to 450,000 interested prospects.
- Distribute new specialty brochures for selected market segments.
- Operate ongoing fulfillment program to respond to mail, electronic and phone requests for information.

Strategy 2: Encourage destination marketing organizations and visitor industry businesses to provide product specific information to prospective visitors and travel trade

Tactics:

- Make prospective visitors names and addresses available to destination marketing organizations and visitor industry businesses.
- Update discriminate analysis model to increase effectiveness of leads provided to destination marketing organizations and visitor industry businesses.
- Make trade event contact leads available to destination marketing organizations and visitor industry businesses.
- Make web site and e-mail addresses available to destination marketing organizations and visitor industry businesses, as allowable by law.

Domestic Trade Marketing Programs

Creating interest among the consumer market is only one part of the essential destination marketing for Alaska. Once consumers have made the decision to travel to Alaska, an outlet where they can buy their travel should be a available. And since the vast majority of visitors to Alaska are from the U.S., domestic travel trade (travel agents and tour operators) is one of the most important areas for ATIA to target. From the standpoint of the travel trade, the program needs to generate agent and operator interest and offer extensive education. Since Alaska is such a big state with so many different modes of transportation, attractions, and variables in general, Alaska is a potentially difficult destination to sell. The up side to the difficulty a novice agent or operator might have in selling Alaska is that when they actually see Alaska, they are truly committed to learning about and selling the destination. For these reasons the following tactics are suggested.

Strategy 1: Provide Alaska travel information to and contacts with tour operators and wholesalers

Tactics:

- Anchor Alaska's participation at the National Tour Association (NTA) convention and tour & travel exchange in Salt Lake City in November 2000.
- Assist the Anchorage Convention Visitor Bureau with the planning and coordination of the NTA Spring Meet to be held in Anchorage in March 2001.
- Anchor Alaska's participation in the American Bus Association (ABA) convention in January 2001.
- Organize and sponsor Alaska familiarization tours for the travel trade tour wholesalers and operators culminating in Alaska Travel Fair market place for buyers and Alaska sellers in Valdez in September 2000.
- Participate in the Non-Profits in Travel program in February 2001.
- Participate in the Receptive Services Association conference.
- Co-sponsor with Anchorage Convention & Visitors Bureau World Congress on Adventure Travel & Eco-Tourism in Anchorage in September 2000.

Strategy 2: Conduct a series of retail travel agent educational workshops in key U.S. markets

Tactics:

- Schedule in appropriate markets immediately before or after Pow Wow, NTA, ABA, and other planned events.
- Encourage participation by destination marketing organizations and private sector businesses to showcase their destinations and products.
- Survey travel agents on their perceptions of quality and content and apply input to future educational workshops.

Strategy 3: Develop Top-of-the-World Specialist online program for the travel trade

Tactics:

- Make recommendations for content refinements and enhancements.
- Pursue potential endorsement of the program by the Institute of Certified Travel Agents (ICTA) that would allow travel agents the ability to earn credit toward Certified Travel Agent (CTA), Certified Travel Counselor (CTC), and Certified Tour Professional (CTP) certifications.

International Travel Trade Marketing

The role of the international programs in the ATIA marketing plan is to reach out to the highest potential international markets and provide image awareness, trip-planning, and product information. Just as domestic visitors come in a wide variety; so do international visitors. Hence, the need to ensure that Alaska and its visitor-industry businesses respond to international markets with a wide selection of activities, attractions, and experiences.

What is Alaska's international market?

Based upon past experience and Alaska visitor research, we know that the majority of our international visitors (not including Canadians) come from Japan, German-speaking Europe and the United Kingdom (UK), with smaller numbers arriving from Australia and other Asian countries.

Japan has emerged as our most important off-season market, with 50 percent of Japanese visitors coming to Alaska in the middle of winter for activities anchored around Aurora viewing. Northwest Airlines initiated the scheduled turn-around, non-stop air service between Alaska and a foreign country, operating once weekly in the summer of 1998 and 1999. This created tremendous opportunity for substantial growth in summer visitation of Japanese visitors to Alaska. Northwest recently announced it would suspend this service for 2000 and 2001 until the Narita Airport expansion in Japan is completed.

Germany, together with Austria and Switzerland, represents Alaska's largest (non-North American) international visitor market. For five years, seasonal non-stop charter flights have operated into Anchorage from Frankfurt, Cologne and Zurich. The visitors traveling on these flights have a propensity to take long vacations in Alaska, and to visit a wide variety of Alaska destinations.

The United Kingdom continues to show promise as the next big inbound market for Alaska. As the UK economy strengthens, the UK traveler wants to see more than Florida, New York and California -- and can afford to. This market is also becoming more adventure-based, requiring more active holidays. Although there are no direct flights between the UK and Alaska, increased non-stop service between London or the continent and Seattle and Vancouver, has greatly improved Alaska's positioning as a destination.

The ATIA international program will focus primarily upon the travel trade, with particular emphasis on attending international trade shows and conducting travel trade training and familiarization trips.

Strategy 1: Foster Alaska travel interest and provide planning information within the Japanese market

Tactics:

- Maintain local representation in Japan to enhance, facilitate and assist in providing direction for Alaska tourism marketing and sales activities.
- Participate in Japan Visit USA program to be held in October 2000.
- Organize, sponsor and host an Alaska trade familiarization tour in Alaska in January 2001.
- Host Alaska Trade Workshops in Japan in April 2001.

Strategy 2: Foster Alaska travel interest and provide planning information within German-speaking Europe market

Tactics:

- Maintain local representation in German-speaking Europe to enhance, facilitate and assist in providing direction for Alaska tourism marketing and sales activities.
- Participate in ITB in March, 2001, anchoring Alaska's participation for other destination marketing organi zations and private sector businesses by sponsoring a statewide booth and sharing space with Alaskan vendors.

International Trade Show Schedule

	2000						2001					
	July	Aug.	Sept.	Oct.	Nov.	Dec	Jan.	Feb.	March	April	May	June
Japan Visit USA				■								
ITB - Berlin									■			
World Travel Market					■							
TIA's International Pow Wow											■	

International Travel Trade Workshop/FAM

	2000						2001					
	July	Aug.	Sept.	Oct.	Nov.	Dec	Jan.	Feb.	March	April	May	June
Japan Trade Alaska FAM							■					
UK Trade Workshops									■			
Alaska Travel Fair			■									
Australian Trade Workshop								■				
Alaska Travel Workshop in Japan										■		

Strategy 3: Foster Alaska travel interest and provide planning information within the United Kingdom market

Tactics:

- Maintain local representation in the United Kingdom to enhance, facilitate, and assist in providing direction for Alaska tourism marketing and sales activities.
- Participate in the World Travel Market in London in November 2000, anchoring Alaska's participation for other destination marketing organizations and private sector businesses by sponsoring a statewide booth and sharing space with Alaska vendors, and distributing private sector brochures.
- Sponsor a series of travel trade educational workshops in the UK to be held in March 2001, immediately following ITB in Germany.

Strategy 4: Foster Alaska travel interest and provide planning information within the Australian market

Tactics:

- Maintain local representation in Australia to enhance, facilitate, and assist in providing direction for Alaska tourism marketing and sales activities.
- Organize and sponsor a series of travel trade educational workshops in Australia in February 2001.

Strategy 5: Provide planning information within other International Markets

Tactics:

- Maintain local representation in Taiwan for the purposes of distribution of trip planning information.
- Maintain local representation in Korea for the purposes of distribution of trip planning information.

Strategy 6: Organize, sponsor and participate in a variety of activities targeted to international wholesalers and operators

Tactics:

- Participate in the Travel Industry Association of America's (TIA) International Pow Wow in May 2001.
- Organize and sponsor Alaska familiarization tours for the international travel trade tour wholesalers and operators culminating in an Alaska Travel Fair market place for international buyers and Alaska sellers in Valdez in September 2000.

Tourism North

Tourism North is a cooperative tourism marketing program between Alaska and several Canadian provinces (The Yukon, British Columbia, and Alberta.) The purpose of this effort is to (1) increase the number of people traveling through northern British Columbia and the Yukon Territory to Alaska, (2) improve the tourism opportunities for highway visitors in each of the three jurisdictions, and (3) increase the length of stay and amount of money spent by these highway visitors per day. Alaska's participation is 20% of the total program budget, and the state's $250,000 investment is leveraged to a $1 million + program.

Strategy 1: Provide potential highway and marine highway travelers with planning information

Tactics:

- Produce and distribute 400,000 copies of *North! to Alaska.*
- Refresh and update *North! to Alaska* content.
- Incorporate the Alaska Marine Highway System schedule and tariffs.
- Maintain and upgrade Tourism North's consumer web site.

Strategy 2: Increase awareness of highway and marine highway travel opportunities

Tactics:

- Design and implement a public relations campaign to stimulate news coverage of highway travel.
- Design and implement a direct-to-consumer advertising program through the use of cooperative marketing opportunities

Research

The role of Research in the ATIA marketing plan is to provide market research to Alaska's visitor industry and to measure the effectiveness of the ATIA programs. Generally, the research undertaken by ATIA will help us accomplish the following:

1. To monitor and evaluate the effectiveness of marketing programs.
2. To learn more about Alaska's visitors – who they are; why they came; their purchase decisions, trip arrangements, and activities; and their perceptions and evaluations of their Alaska trips.
3. To learn more about Alaska's potential visitors – how they plan vacations, who they are, their attitudes toward Alaska travel, their psychographics, etc.
4. To provide tools and information to ATIA members to enhance individual marketing efforts.

Strategy 1: Determine the effectiveness and efficiency of ATIA's marketing program

Tactics:

- Conduct a study of media to determine effectiveness of ATIA marketing activities.
- Survey participants in selected ATIA marketing programs.

Strategy 2: Survey potential and actual visitors to Alaska

Tactics:

- Assist with Alaska Visitor Statistics Program Study of actual FY00 visitors.
- Complete Images IV study of potential and actual visitors, including repeat visitors and Fall/Winter/Spring visitors.

Strategy 3: Provide tools and infor ATIA members to enhance individu marketing efforts

Tactics:

- Conduct seminars to better understand a research from various studies.
- Make research available through market partnerships.

Market Segments Program Overview

As part of its commitment to expand the statewide marketing campaigns developed for Alaska's visitor industry, the Alaska Travel Industry Association will feature winter tourism, highway and marine highway, and special niche segments (such as sport-fishing, cultural tourism, adventure eco-tourism, bed & breakfasts) throughout its FY01 marketing activities.

Winter

One of the key goals of the Alaska Travel Industry Association is to "endeavor to position Alaska as a year-round destination." As such, each of the marketing strategies developed for FY01 has a mandated element to include year-round focus and activities. Additionally, special winter marketing tactics have been designed to strengthen Alaska's winter image and to attract new winter visitors.

Featured winter marketing tactics include winter media press trips, proactive efforts to pitch winter story ideas to a variety of media sources, winter image features in our direct-mail and advertising campaigns and our winter web address featured in appropriate advertising, and expansion of the winter section on the ATIA web-site.

Winter-focused marketing activities and tactics include:

- Conduct press trips during winter season
- Assist travel writers/editors with winter stories
- Pitch winter story ideas to the media to increase their awareness
- Consider winter tourism specialty brochure
- Support winter tourism brochure with specialty magazine advertising
- Feature winter images in direct mail and ad campaigns
- Feature ATIA winter web address in appropriate advertising
- Enhance and maintain ATIA winter section on website
- Enhance website trip planning tool to include winter product
- Include winter product in Alaska Travel Fair in September, 2000
- Include winter product information in travel agent workshops and trainings
- Be active in the annual Winter Tourism Conference
- Survey past winter visitors during Images IV study to learn about travel patterns, attitudes toward Alaska, visitor demographics, etc

Highway And Marine Highway

Another key goal of the Alaska Travel Industry Association is to "attract a diverse mixture of visitors who travel to and within Alaska by a variety of travel modes." As such, the ATIA has developed a variety of marketing strategies for FY01 designed to strengthen Alaska's highway and marine highway markets.

Featured highway and marine highway marketing tactics include advertising in highway travel magazines, sending Alaska travel information to potential highway visitors via direct-mail program, and participating in the Tourism North marketing program that produces and distributes 400,000 copies of North! To Alaska and maintains a highway-focused consumer website.

Highway and marine highway focused marketing activities and tactics include:

- Advertise in highway travel magazines such as Ari ona Highroads (AAA), Coast to Coast, Colorado Motorist (AAA), Home & Away, Journey WA (AAA), Midwest Traveler (AAA), Trailer Life, VIA (AAA) and Westways (AAA)

- Send direct mail materials to names from highway travel oriented lists such as Target Source – RV/No Kids, Good Sam Club, Motorhome, Trailer Life, and RV Book and Directory
- As partner in Tourism North, produce and distribute 400,000 copies of *North! To Alaska*, including the Alaska Marine Highway System schedule and tariffs
- As partner in Tourism North, maintain and upgrade Tourism North highway-focused consumer website
- As partner in Tourism North, design and implement public relations campaign to stimulate news coverage of highway travel

Special Niche Segments

An especially important goal of the Alaska Travel Industry Association is to "attract a diverse mixture of visitors who travel to and within Alaska." As such, the ATIA has developed a variety of marketing strategies for FY01 designed to feature and enhance small business opportunities of special niche segments (such as sport-fishing, cultural tourism, adventure eco-tourism, and bed & breakfasts).

Beginning with the cover of the Official Alaska State Vacation Planner, which will feature an Alaska Native motif, to special e-news bulletins distributed to hundreds of travel press monthly, and including up to four new specialty brochures featuring small businesses from around Alaska, the ATIA FY01 marketing program has a ma or commitment to attracting a diverse mixture of visitors to Alaska.

Sport fishing tactics include:

- Consider sport fishing specialty brochure
- Support sport fishing brochure with specialty magazine advertising
- Develop sport fishing section on ATIA website to complement specialty brochure
- Test direct mail program to past out-of-state purchasers of Alaska Fishing Licenses

Cultural Tourism tactics include:

- Design Alaska Native motif for cover of Official Alaska Vacation Planner
- Consider Cultural Tourism specialty brochure
- Support Cultural Tourism brochure with specialty magazine advertising
- Develop Cultural Tourism section on ATIA website to complement specialty brochure
- Develop press releases, e news bulletins and new travel stories with cultural tourism content
- Advertise in national magazines that appeal to cultural tourism visitors
- Test direct mail program with lists such as National Geographic Traveler, Alaska Magazine and Premier Luxury Class

Adventure-Eco Tourism tactics include:

- Consider Adventure-Eco Tourism specialty brochure
- Support Adventure-Eco Tourism brochure with specialty magazine advertising
- Develop Adventure-Eco Tourism section on ATIA website to complement specialty brochure
- Develop press releases, e news bulletins and new travel stories with adventure-eco tourism content
- Advertise in national magazines that appeal to adventure-eco tourism visitors such as Canoe & Kayak Magazine, National Parks Magazine, National Wildlife, Outdoor Life, Outdoor Photographer, Outside, and Audubon
- Test direct mail program with lists such as National Geographic Traveler, National GEO Adventure, Adventures Abroad, and Last Frontier Alaska
- Co-sponsor, with Anchorage Convention and Visitors Bureau, World Congress on Adventure Travel & Eco-Tourism Anchorage in September, 2000

Bed & Breakfast tactics include:

- Consider Bed & Breakfast section on ATIA website.
- Support Bed & Breakfast web section with specialty magazine advertising

Partnership Programs

With a legislative mandate to match public funds with private funds on an ever-increasing basis, the Alaska Travel Industry Association will be very dependent on its Marketing Partnership Programs to generate the private-industry match. Much of this effort will involve the recruitment of new Partners and new Partnership opportunities beyond the traditional ad sales and label programs managed by the Alaska Visitors Association and the Alaska Tourism Marketing Council.

Already, beginning in this first year of the Alaska Travel Industry Association's marketing efforts, innovative new partnership opportunities have been developed and many more are in the works. This year the Board of Directors and Marketing Committee have focused particularly upon new Internet programs and new small business-oriented niche market segment programs for development of new Partnership opportunities.

The Alaska Travel Industry Association will be investing more than $250,000 in new Internet programs to attract visitors to the ATIA website – where marketing partnership opportunities are being expanded to increase the ability of small businesses to reach new customers and markets. Additionally, the Alaska Travel Industry Association will be investing more than $300,000 in new specialty brochures that will feature special niche segments (such as sport-fishing, cultural tourism, adventure eco-tourism, and bed & breakfasts). Again, ATIA will be providing new opportunities for Alaska's small visitor industry businesses to attract new customers and markets.

Current Marketing Partnership Programs include:

- Cooperative major-market newspaper ad buys
- Internet advertising strategies, such as Alaska travel discount offer
- Listing, narrative, and display ads in the Official Alaska State Vacation Planner
- Listing, narrative, and display ads in Specialty Brochures
- Business listings and website links on the ATIA website
- Banner ads on appropriate "inside pages" on the ATIA website
- Purchase leads generated through ATIA marketing programs
- Purchase leads generated through travel trade activities
- Participation in domestic and international Travel Trade Shows with ATIA
- Participation in Alaska Travel Fair
- Participation in travel agent educational work shops and training
- Educational seminars designed to explain research programs, how to take advantage of programs, and what we've learned from research results
- Research studies and documents

Appendix

FY01 Marketing Budget

Marketing Research	
Conversion Study	$145,000
Images IV remaining costs	15,000
Program Implementation	24,000
Total Research	**$184,000**

Consumer Marketing	
Public Relations	
Media Outreach & Assistance	$130,500
Summer Press Trips	27,000
New Story Packages	6,000
Media Kits	2,750
Crisis Communications/DMO Briefings	2,750
1-800 number, Clip Service etc	21,000
BR Agency Administration	30,000
Program Implementation	46,900
Total Public Relations	$266,900
Advertising	
Magazine and Direct Mail	$2,084,655
Joint Yukon Program	220,000
Advertising of Internet Site	331,000
1-800 Number	15,000
Ad Agency Direct Expense	113,000
Talent, Tapes & Shipping	12,500
List Rental Program	65,000
Program Implementation	278,250
Total Advertising	$3,119,405
Internet*	
Site Development	$90,000
Site Hosting	10,000
Program Implementation	48,500
Total Internet	$148,500
Total Consumer Marketing	**$3,534,805**

Niche Marketing	
Winter Press Trip	$ 36,000
Winter Promotions	17,000
Niche Advertising	200,000
Tourism North	250,000
Niche Brochure Program	180,000
World Congress on Adventure Travel	22,500
Program Implementation	66,750
Total Niche Marketing	**$772,250**

Inquiry Fulfillment	
Vacation Planner	$1,209,712
Inquiry Section	70,000
Program Implementation	194,400
Total Inquiry Fulfillment	**$1,474,112**

Trade International Marketing	
Travel Shows & Memberships	$ 103,600
International Contracts	
Japan	267,466
German-Speaking Europe	198,062
UK	109,576
Australia	71,500
Taiwan Fulfillment	3,000
Korean Fulfillment	2,500
Program Implementation & Admin.	207,700
Total Trade & International Marketing	**$963,404**

Total	**$6,928,571****

* Promotion of web site listed under Consumer Marketing – Advertising

** ATIA anticipates supplementing the FY 01 Marketing Plan with up to $489,00 in additional marketing expenditures.

FY01 DIRECT MAIL
PROJECTED RESPONSE BY DROP MATRIX
VERSION 1.0

Mailing/Lists	Mail Quantity	% Response Projections	# Response Projections
September - Control Lists			
PI D'00 GOLD GOV	20,000	22%	4,400
PI D'00 BLUE GOV	20,000	16%	3,200
PI D'01 MODEL-GOLD GOV	45,000	28%	12,600
PI D'01 MODEL-BLUE GOV	20,000	21%	4,200
PI D'01 CONTROL- GOLD GOV	45,000	28%	12,600
PI D'01 CONTROL- BLUE GOV	20,000	21%	4,200
PI LIKELY 3YR- GOLD GOV	20,000	23%	4,600
PI LIKELY 3YR- BLUE GOV	20,000	20%	4,000
PI LIKELY ?- GOLD GOV	20,000	23%	4,600
PI LIKELY ?- BLUE GOV	20,000	20%	4,000
ALASKA MAGAZINE	21,400	17%	3,638
NATIONAL GEO TRAV-DIRECT	82,000	16%	13,120
TARGET SOURCE-RV/NO KIDS	46,000	16%	7,130
BUYERS CHOICE/VACATION/CRUISE	60,000	15%	9,240
TARGET SOURCE-CRUISE/FOR/NO KIDS	85,000	15%	12,750
DONNELEY- FOR/NO KIDS	22,000	15%	3,300
BEHAVIOR BANK-COLLEGE/FOR/NO KIDS	18,600	15%	2,790
SUBTOTAL	**585,000**		**110,368**
September - Back Test Lists			
GOOD SAM CLUB	25,000	14%	3,500
LIFESTYLE SEL-FF/FOR/NO KID	25,000	14%	3,500
MOTORHOME	25,000	14%	3,500
LIFESTYLE SEL-CRUISE/NO KID	25,000	14%	3,500
TRAILER LIFE	25,000	14%	3,500
ALASKA AIRLINES	9,000	14%	1,260
TARGET SOURCE-DOM TRAV/CAMP/NO KIDS	9,000	14%	1,260
READERS DIGEST-CRUISE/FOR/NO KIDS	9,000	14%	1,260
SUBTOTAL	**152,000**		**21,280**
September - Test Lists			
BOTTOM LINE TOMORROW	8,500	10%	850
TRAVEL HOLIDAY CLUB	8,500	10%	850
TRAVEL AMERICA	8,500	10%	850
AARP	8,500	10%	850
RV BOOK AND DIRECTORY	8,500	10%	850
CRUISE AMERICA	8,500	10%	850
ECONO SENIOR TOURS	8,500	10%	850
PREMIER LUXURY CLASS	8,500	10%	850
SUBTOTAL	**68,000**		**6,800**
SEPT TOTAL	**805,000**		**138,448**

FY01 DIRECT MAIL
PROJECTED RESPONSE BY DROP MATRIX
VERSION 1.0

Mailing/Lists	Mail Quantity	% Response Projections	# Response Projections
October - Control Lists			
PI D'00 GOLD GOV	20,750	22%	4,565
PI D'00 BLUE GOV	17,500	16%	2,800
PI LIKELY 3YR- GOLD GOV	20,000	23%	4,600
ALASKA MAGAZINE	21,400	17%	3,638
NATIONAL GEO TRAV-DIRECT	82,000	16%	13,120
TARGET SOURCE-RV/NO KIDS	46,000	16%	7,130
BUYERS CHOICE/VACATION/CRUISE	60,000	15%	9,240
TARGET SOURCE-CRUISE/FOR/NO KIDS	85,000	15%	12,750
DONNELEY- FOR/NO KIDS	22,000	15%	3,300
BEHAVIOR BANK-COLLEGE/FOR/NO KIDS	18,600	15%	2,790
SUBTOTAL	**393,250**		**63,933**
October- Test List			
NATIONAL GEO ADVENTURE	8,500	10%	850
ADVENTURES ABROAD	8,500	10%	850
TWA AMBASSADORS CLUB	8,500	10%	850
BACKROADS	8,500	10%	850
LAST FRONTIER ALASKA	8,500	10%	850
NAEA CRUISE AND TRAVEL	8,500	10%	850
FROMMER BUDGET TRAVEL	8,500	10%	850
SUBTOTAL	**59,500**		**5,950**
OCT TOTAL	**452,750**		**69,883**
November - Control Lists			
PI D'00 GOLD GOV	20,750	22%	4,565
PI D'00 BLUE GOV	17,500	16%	2,800
PI LIKELY 3YR- GOLD GOV	20,000	23%	4,600
ALASKA MAGAZINE	21,400	17%	3,638
NATIONAL GEO TRAV-DIRECT	82,000	16%	13,120
TARGET SOURCE-RV/NO KIDS	46,000	16%	7,130
BUYERS CHOICE/VACATION/CRUISE	60,000	15%	9,240
TARGET SOURCE-CRUISE/FOR/NO KIDS	85,000	15%	12,750
DONNELEY- FOR/NO KIDS	22,000	15%	3,300
BEHAVIOR BANK-COLLEGE/FOR/NO KIDS	18,600	15%	2,790
NOV TOTAL	**393,250**		**63,933**

FY01 DIRECT MAIL
PROJECTED RESPONSE BY DROP MATRIX
VERSION 1.0

Mailing/Lists	Mail Quantity	% Response Projections	# Response Projections
January - Control Lists			
PI D'00 GOLD GOV	20,750	22%	4,565
PI D'00 BLUE GOV	17.500	16%	2,800
PI LIKELY 3YR- GOLD GOV	20.000	23%	4,600
ALASKA MAGAZINE	21,400	17%	3,638
NATIONAL GEO TRAV-DIRECT	82.000	16%	13,120
TARGET SOURCE-RV/NO KIDS	46,000	16%	7,130
BUYERS CHOICE/VACATION/CRUISE	60,000	15%	9.240
TARGET SOURCE-CRUISE/FOR/NO KIDS	85.000	15%	12,750
DONNELEY- FOR/NO KIDS	22.000	15%	3,300
BEHAVIOR BANK-COLLEGE/FOR/NO KIDS	18.600	15%	2,790
JAN TOTAL	**393,250**		**63,933**
February- Control Lists			
PI D'00 GOLD GOV	20,750	22%	4.565
PI D'00 BLUE GOV	17,500	16%	2.800
PI LIKELY 3YR- GOLD GOV	20,000	23%	4,600
ALASKA MAGAZINE	21,400	17%	3,638
NATIONAL GEO TRAV-DIRECT	82.000	16%	13,120
TARGET SOURCE-RV/NO KIDS	46.000	16%	7,130
BUYERS CHOICE/VACATION/CRUISE	60,000	15%	9,240
TARGET SOURCE-CRUISE/FOR/NO KIDS	85,000	15%	12,750
DONNELEY- FOR/NO KIDS	22.000	15%	3,300
BEHAVIOR BANK-COLLEGE/FOR/NO KIDS	18.600	15%	2.790
FEB TOTAL	**393,250**		**63,933**
FY01 DIRECT MAIL TOTALS	**2,437,500**		**400,130**

Alaska Travel Industry Association Marketing Advisory Committees

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Ann Campbell, Chair ATIA
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Gary Odle, Chair Trade Development Subcommittee
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Jerre Fuqua, Chair Advertising Subcommittee
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President and Marketing Chair are ex-officio of all marketing committees