OVERVIEW: DFYS TRANSITION TO OCS

Child Protection and Permanency

Child Welfare Services focus on protection of children at risk of abuse or neglect and finding permanent homes for those who cannot be maintained in their own families. These services are managed regionally and delivered out of 28 local offices throughout Alaska

To meet the mission, Child Protective Services screens and investigates reports of harm, places children who may not be safe in their own homes with relatives or foster families. Permanency planning services include family preservation and support, reunification, foster care, adoption and guardianship. The OCS also provides services that prepare youth who are in custody to achieve success at the age of independence. In addition, OCS recruits, trains, and licenses foster and adoptive families and provides behavioral rehabilitation services for youth who need mental health settings.

Organizational information:

- Child Welfare Services has a budget of 101.5 million dollars and approximately 50% of this is funded with federal funds. The major funding sources are Title IVE, Medicaid, Social Services Block Grant and TANF.

- There are 363 workers in the four regions; of this there are 200 child protection workers, 52 supervisors, 8 mental health professionals, 70 clerks, and 33 positions providing management and administration.

- From July 2003 thru December 2003, employee turnover rate =13%; employee vacancy rate was 7.5%.

- There are 28 Residential Care grants, 28 Family Preservation and Support grants, 17 Alaska Children's Trust grants, 8 Child Advocacy Center grants.

- The Federal Government accepted Alaska's Program Improvement Plan in September 2003. The Plan addresses issues where Alaska did not achieve substantial conformity during the June 2002, Federal Child and Family Services Review.

- Alaska is still struggling to meet national standards:

  Repeat Maltreatment: (National Standard is 6.1% or less)
  Alaska: FFY '01 –25.4%
  FFY '03 – 17.6% (shows improvement)

  Child Abuse and Neglect in Foster Care: (National Standard is .57 or less)
  Alaska: FFY '01 - 2%
  FFY '03 – 2.07%

  Children in Care less than 12 mo. w/no more than 2 placemt settings: (Nat'l Std = 86.7%)
  Alaska: FFY '01 – 75.8%
  FfY '03 - 74%

Children reunified within 12 months of removal from home (Nat'l Std=76.2%)
Alaska: FFY '01 – 62.4%
FFY' 03 – 59.3%

Children adopted within 24 months of entry into care (Nat'l Std = 32%)
Alaska: FFY ' 01 – 20.9%
FFY '03 - 23.9% (shows improvement)

- First Quarter PIP Accomplishments --Safety

Revised Policy and Procedure to improve timeliness of investigations;

Enhanced Advanced Risk Assessment Training;

Structured Decision Making now being utilized as a decision making tool in opening in home cases;

Enhanced training on identification and documentation of substance abuse/addiction studies related to child protection - Training on protecting children in substance-abusing families to be conducted in **Spring of 2004**.

Judicial Training on substance abuse, with an emphasis on child welfare cases, occurred on October 15, 2003.

Research to evaluate effectiveness of family preservation services is underway.

Improved data entry to accurately reflect incidents of repeat maltreatment.

Children's Services Managers have conducted review of current employee work schedules and staffing patterns in relation to caseload.

Improved data integrity for differentiating between licensing complaints and child protection allegations in alternate caregiver homes

Begun work on statewide foster home recruitment and retention plan

- Ist Quarter PIP Accomplishments--Permanency

Developed and implemented revised curriculum for Foster and Adoptive Core Training via distance delivery

Changes made to adoption training curriculum to review 1) what concurrent planning is, 2) how concurrent and case planning are done and new P&P.

Clarified existing Policy and Procedure regarding documentation of compelling reasons and trained supervisors.

Trained supervisors on use of reunification assessments through SDM

New policies and procedures were developed and implemented.

Supervisors were trained in the new procedures; line workers received training in the updated procedures during TONE

Advanced Adoption training curriculum has been revised to incorporate the changes. Implemented a statewide contract for post adoption AFPTC is currently in the process of curriculum development and services are scheduled to begin January of 2004.

Implemented Permanent Families contract with Fairbanks Counseling and Adoption and Catholic Social Services

Work has begun on development of dual licensure process for foster and adoptive families

Developed youth advisory board (YAB) to help identify service gaps and improve service delivery

Through the Tribal-State Independent Living committee, develop and implement a prioritized work-plan for meeting the transition needs of native youth in state custody

Training for workers, foster parents and service providers on Understanding Adolescence and Transition Case Planning

Create a statewide network of local experts on assessing life skills, creating transition plans and accessing IL funds

Implemented INGENS statewide for relative searches

Regional clerk to providing notices to case conferences and court hearings.

- First Quarter PIP Accomplishments- Well-Being

Synchronized adoption/guardianship home studies with establishment of concurrent planning goal

Policy has changed to require that home studies will be requested when a concurrent planning goal of adoption or guardianship is created.

The Quality Assurance System for field case reviews has been developed and is in the initial implementation stage.

- Other Activities that are not part of the PIP

ORCA, the automated case management system is due to be fully implemented in August 2004.

Repeat Maltreatment Study completed during the week of January 26th.

Rasmuson Foundation agrees to fund the Family to Family Foster Care Reform Initiative.

Three days of Strategic Planning In January 2004 included stakeholders from all over the state.

Tribal –State Collaboration Group continues to meet quarterly to address ICWA issues.

Recruitment and Retention Committee meeting regularly to address workforce issues.

Improving the quality of supervision and emphasis on accountability

Aggressive Federal Refinancing

- Need for Staff Resources to improve outcomes:

New staff needed to implement the Quality Assurance requirements of the PIP and to be able to do regular review of cases.

Support staff needed to help workers with tasks that do not require a professional (transportation, data entry, supervise visitation, relative searches)

Need frontline staff to respond to investigations in a timely manner.

Need to frontline staff who can help parents achieve their case plan requirements.

Need frontline staff to expedite adoptions and guardianships for children who cannot return home.

Need to lower caseloads

Need a structured independent living program for youth who are aging out of care.

Need quality supervisors who can mentor and train new workers.

Alaska
Department of Health
and
Social Services

Office of Children's Services

Presentation to the HESS Committee
February 10, 2004

Joel Gilbertson, Commissioner
Marci Kenna,Deputy Commissioner

The Mission:

The Office of Children's Services works in partnership with families and communities to support the well-being of Alaska's children and youth. Services will enhance capacities of families to give their children a healthy start, to provide them with safe and permanent homes, to maintain cultural connections and to help them realize their full potential.(February 2004)

Vision:

Stronger Families, Safer Children

Smile Alaska Style

OCS Basics

Prevention and Well-Being

- Family Nutrition Services: Grantees provide services to pregnant and post-partum women with children up to age 5. Includes nutrition education, training, breastfeeding support, obesity and chronic disease prevention, and provision of appropriate supplemental foods.
- Healthy Families Alaska: HFAK grantees visit families with children under 3, who have an identified risk factor for child abuse or neglect.
- Infant Learning Program-ILP grantees screen and assess children, Infant-3, with identified risks for developmental delays.

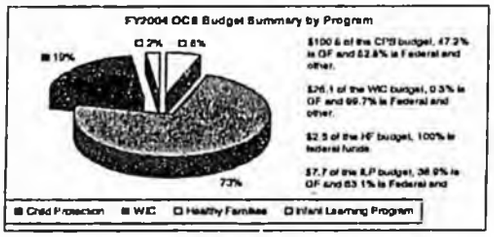
OCS Basics (cont'd)

Protection and Permanency

- Child Protective Services: Protection of children who are the subjects of reports of harm through the provision of services that include:
  - Screening of reports of harm
  - Investigation of reports of child abuse and/or neglect,
  - Family preservation
  - Out of home placement
  - Reunification, adoption, guardianship,
  - Behavioral rehab services,
  - Recruitment and licensing of foster and adoptive homes
  - Independent living services for youth
  - Research,Evaluation, Quality Assurance
  - Federal Financing

Budget

The FY2004 OCS operating budget is $137.2 million. Approximately 32% ($52.5) is funded with state General Fund and the remaining 68% ($84.6) is funded with federal and other funding sources.



Federal Review of the Child Protection Program

In June of 2002, the Federal government completed the Child and Family Services Review (CFSR) in Alaska. The CFSR consisted of the following activities:

- A Statewide Self-Assessment
- State Data Profile that measured 6 outcomes
- Onsite Review of 50 cases and interviews with stakeholders

Focus of Review was to determine state performance in the areas of
- safety
- permanency
- well-being

Program Improvement Plan(PIP)

Alaska's plan was approved on September 1, 2003, and will be in effect until August 31, 2005. Alaska needs to make progress toward improvement or risk losing federal dollars in the future.

Highlights of the PIP:

Safety

- Activities that reduce repeat maltreatment and the maltreatment of children by foster care providers;
- Activities that focus efforts on responding to all reports of harm according to timeframes set in policy;

Program Improvement Plan (Cont'd)

Permanency
- Activities that address case planning to increase the number of children reunified within 12 months of removal from home;
- Facilitation of visits between parents and their children;
- Clarify policy on visits between worker & child and worker & parents;
- Activities focused on increasing the number of children who are adopted within 24 months of entry into care;
- Increase the stability of placement for those children in custody;
- Improvement in the assessments of children and families to assure that they receive needed services;

Program Improvement Plan (cont'd)

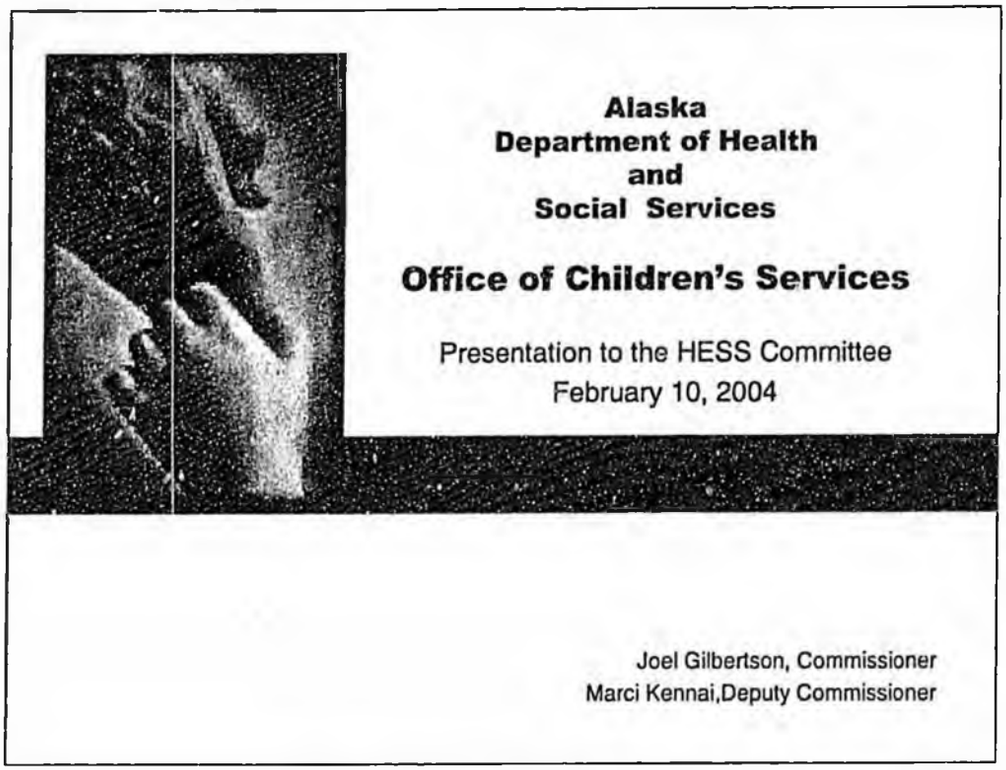
Well-Being:
- Support Foster Parents in their efforts to care for children in their care;
- Assure that children in care are receiving all health, mental health, dental, educational services that meet their needs;
- Assure that children we serve in their own homes are receiving appropriate health care.

Systems Improvement:
- The development of ORCA to improve accountability and performance;
- The development of a comprehensive Quality Assurance (QA) program.
- Improve the array of services available to families.

Other Efforts In Progress

The first progress report was submitted on December 30,2003. It reflected Alaska's progress in achieving the benchmarks for improvement.(See Attachment)

Other initiatives directed at improving the system:
- Task Force to address recruitment and retention of staff;
- Repeat Maltreatment Study completed;
- OCS Strategic Planning Process completed;
- Rasmuson Foundation funded the implementation of Family to Family Foster Care Reform Initiative;
- Renewed focus on accountability and measurement of performance;
- Quality Assurance Reviews will include stakeholders;
- Cross training among all OCS programs;
- Focus on helping tribes/tribal organizations with prevention efforts;



For the record my name is Tom Cherian, Acting Director of DFYS. With me Joanne Gibbens, Program Administrator, in charge of program development and administration and Myra Casey, Field Administrator, in charge of DFYS field operations.

Madam Chair, there are two parts to our overview.

- First an overview of DFYS programs and field operations
- An overview of the review conducted by the Federal government and the findings.

The Mission:

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First I would start with the mission. The mission of the Division of Family and Youth Services is... to protect children by preventing and remedying repeated abuse, neglect, and the exploitation of children.

Vision:

Stronger Families, Safer Children

Smile Alaska Style

DFYS is organized in four regions, has 29 field offices and 399 employees.

The Northern Regional Office is located in Fairbanks and is responsible for Fairbanks, Nome, Kotzebue, Barrow, and surrounding town and villages.

The South-central Regional Office located in Mat-Su and is responsible for the Mat-Su Valley, the Kenai Peninsula, Bethel, Valdez, Kodiak, Dillingham, the Aleutian Islands, and surrounding areas.

The Anchorage Regional Office is located in Anchorage and is responsible for Anchorage.

The Southeastern Regional Office is located in Juneau and is responsible for Juneau, Haines, Sitka, Petersburg, Ketchikan and surrounding communities.

OCS Basics

Prevention and Well-Being

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- ☆ Infant Learning Program-ILP grantees screen and assess children, Infant-3, with identified risks for developmental delays.

In FY2002 DFYS received 15,462 reports of harm and there were 11,142 children involved in these reports.

There were 4 major types of reports of harms. 60% or 9,349 reports of harm was due to neglect, 23% or 3,517 reports of harm was due to physical abuse, 10% or 1,519 reports of harm was due to sexual abuse, and 7% or 1,064 reports of harm was due to mental injury. In addition, there were 13 reports of harm due to abandonment.

In FY02, DFYS workers investigated 12,916 or 92.5% of the legitimate reports of harm. Legitimate meaning that meet the statutory meaning abuse or neglect.

At the end of January there were 2,288 children placed in the custody of DFYS. Of this 1,933 children placed outside their home and the remaining 355 children continued to stay in their own homes under the supervision of DFYS.

There were 1,062 licensed foster homes as of December 2002. We are short of foster homes and continuing our efforts to recruit more foster homes.

We have 47 licensed residential care facilities statewide.

OCS Basics (cont'd)

Protection and Permanency

☆ Child Protective Services: Protection of children who are the subjects of reports of harm through the provision of services that include:

- Screening of reports of harm
- Investigation of reports of child abuse and/or neglect,
- Family preservation
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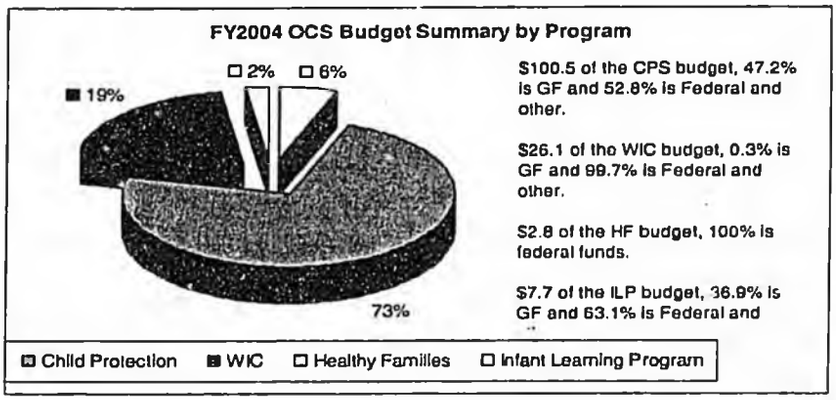

The FY 2004 OCS budget IS $137.2 million. Approximately 32% (52.5 million) is funded with general funds and the remaining 68% (84.6) is funded with federal funds and other funding sources.

73% ($100.5 million) is for child protection services.

19% ($26.1) is for Women, Infants, and Children (WIC) program.

6% ($7.7) is for Infant Learning Program

2% ($2.8) is for Healthy Family Program

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Focus of Review was to determine state performance in the areas of

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- well-being

There are three major program components in DFYS:

General Administration

Field Operations

Program Administration

General Administration includes the Directors Office, budget and financial management, and statewide data processing support.

Program Improvement Plan(PIP)

Alaska's plan was approved on September 1, 2003, and will be in effect until August 31, 2005. **Alaska** needs to make progress toward improvement or risk losing federal dollars in the future.

Highlights of the PIP:

Safety

- Activities that reduce repeat maltreatment and the maltreatment of children by foster care providers;
- Activities that focus efforts on responding to all reports of harm according to timeframes set in policy;

Field Operations includes screening of reports of harm received in the field offices, investigations of reports of harms, permanency planning of children placed in the custody of DFYS, reunification of children with their families that are placed in DFYS custody, adoption or guardianship, and licensing of foster homes and residential care facilities.

Provide training to new and existing social workers.

Program Improvement Plan (Cont'd)

Permanency

- Activities that address case planning to Increase the number of children reunified within 12 months of removal from home;
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- Quality Assurance Reviews will include stakeholders;
- Cross training among all OCS programs;
- Focus on helping tribes/tribal organizations with prevention efforts;

AaNA
Alaska
Nurses
Association

Public Health Nursing in Alaska

Public Health Nurses provide frontline disease prevention and health promotion.

We are facing a dramatic increase in infectious diseases for which we have no cures (SARS, Asian Avian Flu, West Nile Virus, Mad Cow disease, AIDs). Our only hope for containing these diseases is quick identification and isolation. This is the job of Public Health Nurses.

Removing frontline disease detection and treatment could have enormous costs for Alaska.

What Public Health Nurses Do – Public Health Nursing in Alaska has a long history of service to our citizens. Public Health Nurses

- Respond to epidemics and work to control communicable diseases.
- Educate and support children and families to enable them to grow and develop.
- Served all age groups, and populations, across the state.

Frontline Prevention and Disease Control Services – Public Health Nurse are devoted to preventing outbreaks and minimizing epidemics utilizing the most current public health practices at the community and village level. Public Health Nurses

- Vaccinate countless children and adults to protect them against diseases such as measles, pertussis, hepatitis A and B, and HIB meningitis.
- Assist communities to prepare for emerging public health problems, like SARS.
- Screen for, treat, and provide follow-up for communicable diseases, such as tuberculosis, hepatitis, HIV and other sexually transmitted diseases, often catching symptoms in people who do not utilize the main health care systems.

Evolving Issues – Public Health Nursing continues to evolve to meet the ever changing needs of our citizens. They focus proactive approaches to emerging health issues such as

- Disaster preparedness
- Chronic disease and cancer screening
- Family violence
- Family planning
- Injury prevention

AaNA 2207 E. Tudor, Suite 34, Anchorage, AK 99507-1069
(907) 274-0827 ■ fax (907) 272-0292 ■ www.aknurse.org

Public Health Nursing Methods – Public Health Nurses

- Combine their nursing skills with public health science and social sciences to promote and protect the health of populations.
- Collect information to address real and potential health problems that affect the health status of communities and our state.
- Understand the factors that determine health; behavior, biology, environment, and the health care system.
- Utilize assessment skills to identify needs and strengths of individuals and community.
- Improve health by
  - Providing coordination to access needed health services.
  - Providing clinical services if they are not otherwise available.
- Provide important health data that supports policy development to improve the public's health.

Community Focused – Public Health Nurses work with communities to:

- Provide education on health issues and support for healthier lifestyles and personal responsibility.
- Promote healthier parenting, improved health services, and assist the population to identify and access necessary health and social services.

When They Succeed, So Do We

When Public Health Nurses do a great job at protecting us against diseases and educating us about health, we don't see outbreaks or spread of disease, we see only a healthy community. And most of us never stop to notice, or are not aware of, the continuous frontline protections that Public Health Nurses provide in our state.

Public Health Nursing has drastically reduced Alaska's rate of TB infection, infant mortality, HIB encephalitis, measles, and sexually transmitted diseases. We do not want to see increases in these diseases, which they have worked so hard to contain.

Public Health Nurses represent a state and a community asset that should be supported and sustained.

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The American Nurse

The Official Publication of the American Nurses Association

An 'invisible' workforce

ANA works to support public health nursing and public health infrastructure

By Susan Trossman, RN

Nearly 14 years ago, public health nurse Mary J. Finnin, MSN, RN, began examining the incidence of AIDS and HIV among patients served through the Suffolk County, NY, health centers. At that time, U.S. Center for Disease Control and Prevention (CDC) officials were focusing their attention on developing and promoting HIV/AIDS prevention strategies that targeted the nation's most high-risk group: white, homosexual men. But Finnin's community assessment revealed something different.

She learned that the majority of these patients who were living with AIDs or were HIV-positive were African American or Hispanic, and 40 percent were women. The stats also showed that they contracted HIV and AIDS primarily through IV drug use and heterosexual exposure.

"What we discovered was that our trends were very different from the national trend," said Finnin, RN, president of District 19, New York State Nurses Association (NYSNA). By identifying who was at risk in her community and offering a range of preventive care, screening and early intervention services aimed at them, she and her public health colleagues were able to make real improvements in the health of Suffolk County residents. (The number of cases of HIV transmission from mother to baby alone went from more than 15 cases annually to zero following the implementation of the new strategies.)

"We also persuaded the CDC to change its guidelines to better address the needs of other high-risk populations, including women," Finnin said.

Fast forward to the new millennium — a time in which the public has been forced to think about new and frightening threats to their health, such as anthrax, smallpox, the West Nile virus and SARS. And while the need for public health nurses and a solid public health infrastructure seems to be needed more than ever, nurses and other public health officials continue having to fight to keep their services from the budgetary chopping block.

Montana's nearly 120 public health nurses are definitely "hitting a wall" as they try to juggle more and more responsibilities with fewer resources, said Jo Ann Dotson, MSN, RN, maternal child health director for the Montana Department of Public Health and Human Services. Commissioners in one Montana county, for example, just voted to do away with its public health nursing budget, and a number of the counties fund less than one day a week for public health nursing services, said the Montana Nurses Association member.

"People talk about bioterrorism and our need to be prepared," Finnin said. "Public health nurses are the eyes and ears in the community. They have the expertise to spot trends, do case finding, screen for diseases and make referrals.

"When we decrease the number of public health nurses and the services they provide to the community — that's germ warfare."

Making the 'invisible' visible

In 1999, the CDC released its list of the 10 great public health achievements of the century — many of which could not have occurred were it not for the contributions of public health nurses, according to Kaye Bender, PhD, RN, FAAN, the incoming chair of the American Public Health Association's Public Health Nursing section and a recipient

See **Public health** *on page 2* ☛

Public health

(continued from page 1)

of ANA's Pearl McIver Public Health Nursing Award. Among the achievements were healthier mothers and babies, the recognition of tobacco use as a health hazard, and a decline in deaths from coronary health disease and stroke.

Yet when it comes to government services, the public generally views only a handful as vital, such as those provided by firefighters or police officers. After all, who wants to take a gamble on a reduced firefighting workforce when one's house could go up in flames? But ensuring a healthy population?

"Public health nurses are concerned with health promotion and disease prevention," said Bender, a Mississippi Nurses Association member. "Many studies have shown that most of the public does not think about public health and public health nursing unless it doesn't work or until they have a problem. So the work of public health nurses in many ways is invisible."

And people often don't get the concept of population-focused nursing practice. Or, they think that government-provided services only benefit the poor.

"Our concern as public health nurses in the District of Columbia is the health and welfare of our entire population," said Sharon Payne, RN, a public health nurse and nurse consultant with the Medical Assistance Administration of the DC Department of Health. "We make sure the population lives in a healthy environment, we build partnerships with other stakeholders to ensure everyone has access to care, we educate and empower the community, and we advocate and provide primary prevention services."

And although public health nurses work with the vulnerable and the underserved, their activities promote health within the entire community, contends Payne, president of the DC Nurses Association. For example, public health nurses are part of a program called the "48-hour Newborn Initiative," which guarantees an RN visit to any family with a newborn — regardless of income.

Alaska Nurses Association member and public health nurse Hisa Fallico, BSN, RN, agreed that the notion of public health touching all is one that is often lost among consumers.

"People don't make the connection that the hand-washing we're teaching in schools and other public facilities — or the immunizations we give — make the rest of the world safe," said Fallico, program manager for the Department of Health and Human Services, Disease Prevention and Control program based in Anchorage.

Fallico pointed to her department's work. During the July to September back-to-school rush, public health nurses immunized more than 3,500 children. They also saw 2,700 clients as part of their tuberculosis oversight program and performed 975 PPDs during the same time frame.

Her department also is working with Environmental Services on a new public health threat — the influx of rats, once a non-issue in the cold climate of Alaska. And her community recently had to deal with the first suspected case of SARS in Alaska, which tested the ability of emergency response and health care providers to prevent a potential outbreak while allaying the fears of the public. (The case was negative.)

Even when the public has direct contact with public health nurses, they often don't realize it.

"We don't wear a uniform, a badge or a white coat," Fallico said. "We don't have a stethoscope dangling from our neck, and we often are out in the community or in a clinic." Fallico said public health nurses within her state and others have often been mistaken for school nurses, Red Cross nurses, hospital nurses or even health aides who are helping out in the community.

But ANA and RNs nationwide hope to bring the work of public health nurses and the importance of public health to the forefront as health care policy is shaped.

At ANA's June House of Delegates meeting, nurse leaders passed a resolution that calls for ANA to advance the crucial nature of the public health nurse's role in promoting and protecting the health of individuals, families and communities.

"I am so pleased that this measure passed," Bender said. She said the resolution comes at a critical time when nurses are in short supply and attempts to substitute registered nurses in public health roles have resurfaced. Like their hospital staff nurse counterparts, public health nurse jobs are often viewed as solely "skills-oriented."

The resolution also calls for ANA to persuade policymakers to invest in information systems technology and training to strengthen the public health infrastructure — particularly in this post-9/11 world. Bender said that the use of technology has been lagging in most public health departments, although the recent infusion of federal dollars to help public health departments prepare for bioterrorist events and other disasters has helped.

The resolution also directs ANA to advocate for federal funds to health departments to attract, retain and continually enhance the role and compensation of public health nurses; for the better enumeration of public health nurses; and for further development and implementation of quality indicators that are sensitive to public health nursing functions.

Other actions

A large part of Dotson's role in Montana has been to educate the public, and particularly county commissioners, about their responsibilities to protect the public's health — such as tracking and reporting communicable diseases. She also routinely explains to lawmakers ways in which public health nurses function within the community. Unfortunately, many of those ways have been subject to tradition and political whim.

"There is very little understanding as to what public health ought to be," Dotson said. "Particularly in the small communities, if a county commissioner's mom or somebody's aunt needs foot care, then the commissioners believe that's what public health nurses ought to be doing."

As government funding dwindles further, Dotson believes public health nursing departments across the nation need to focus more sharply on what the CDC refers to as the three core functions of public health: assessment,

See **Public health** *on page 3* ☛

Public health

(continued from page 2)

policy-making and assurance.

"That means as public health providers, we must do a needs assessment of our community, make sure policymakers have the right information to make good policy and then make sure all residents have access to the services they need to remain healthy," she said.

Public health nurses also are concerned about improving public health education within nursing school programs, particularly because they want to ensure that there are RNs willing and able to follow in their footsteps.

"We need to develop curricula that show how nursing knowledge and skills can be applied to not only individuals, but also to populations," Payne said. And she and other nurses said that nursing students need to be given a broader range of clinical opportunities in public health, as opposed to limiting their experiences to giving shots at a clinic.

Payne also believes her colleagues should work to develop and implement clear public health nursing tracks within their health departments. These tracks would serve as a way to unify public health nurses working in various divisions, such as maternal-child health and communicable diseases, as well as provide a way for nurses to advance their careers without having to leave the profession.

And in New York, Finnin recently worked to get NYSNA delegates to pass a public health nursing resolution similar to the one ANA nurse leaders approved earlier this year. Finnin's resolution, however, included a measure that calls for state and county health departments to have directors of public health nursing in place.

By having qualified professional nurse directors, there is a better chance of ensuring that public health nurses' voices are heard when policies are developed and implemented, according to Finnin. County nurses also testified before Suffolk County lawmakers, urging them to prevent deeper cuts in public health bureau staff, which decreased from 160 in 1990 to 68 currently.

Fallico said that the public health infrastructure and public health nursing currently are in transition.

"Right now, there is a lot of emphasis on bioterrorism and emergency preparedness," Fallico said. "But I believe the pendulum is swinging back toward the middle, and we'll be able to regain focus on prevention and preparedness."

Not bleak

The public health nurses interviewed for this story agreed that they have and will continue to face challenges — from budget cuts to image problems. But they also clearly enjoy their roles as public health nurses. They enjoy the autonomy of their practice, as well as the camaraderie within their work environment. And while there undoubtedly is a portion of the population who will never understand public health and public health nursing, there are still clients every day who do understand and appreciate the knowledge, skills and caring that public health nurses provide. (For example, the public rallied around nurses when Suffolk County began cutting public health nurse positions and clinics.)

"We also have the ability to impact the health of an entire population when we create and implement good policies," Dotson said.

As a nurse for 50 years, Finnin said that she has been involved in many models of health care. While hospitals seem to focus on medical models — or financial models — public health allows RNs to practice the nursing model of care in the community.

"It's really a professional practice," she said. ■

Susan Trossman is senior reporter of *The American Nurse*.

PUBLIC HEALTH IN AMERICA

Vision:

Healthy People in Healthy Communities

Mission:

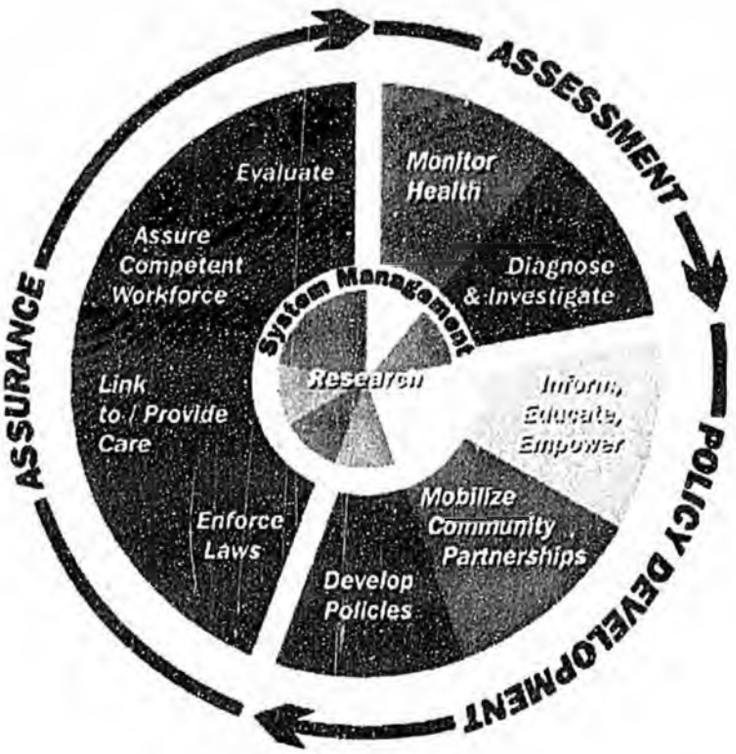
Promote Physical and Mental Health and Prevent Disease, Injury, and Disability

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*

Description	Partners	Structure	Activities	ODPHP

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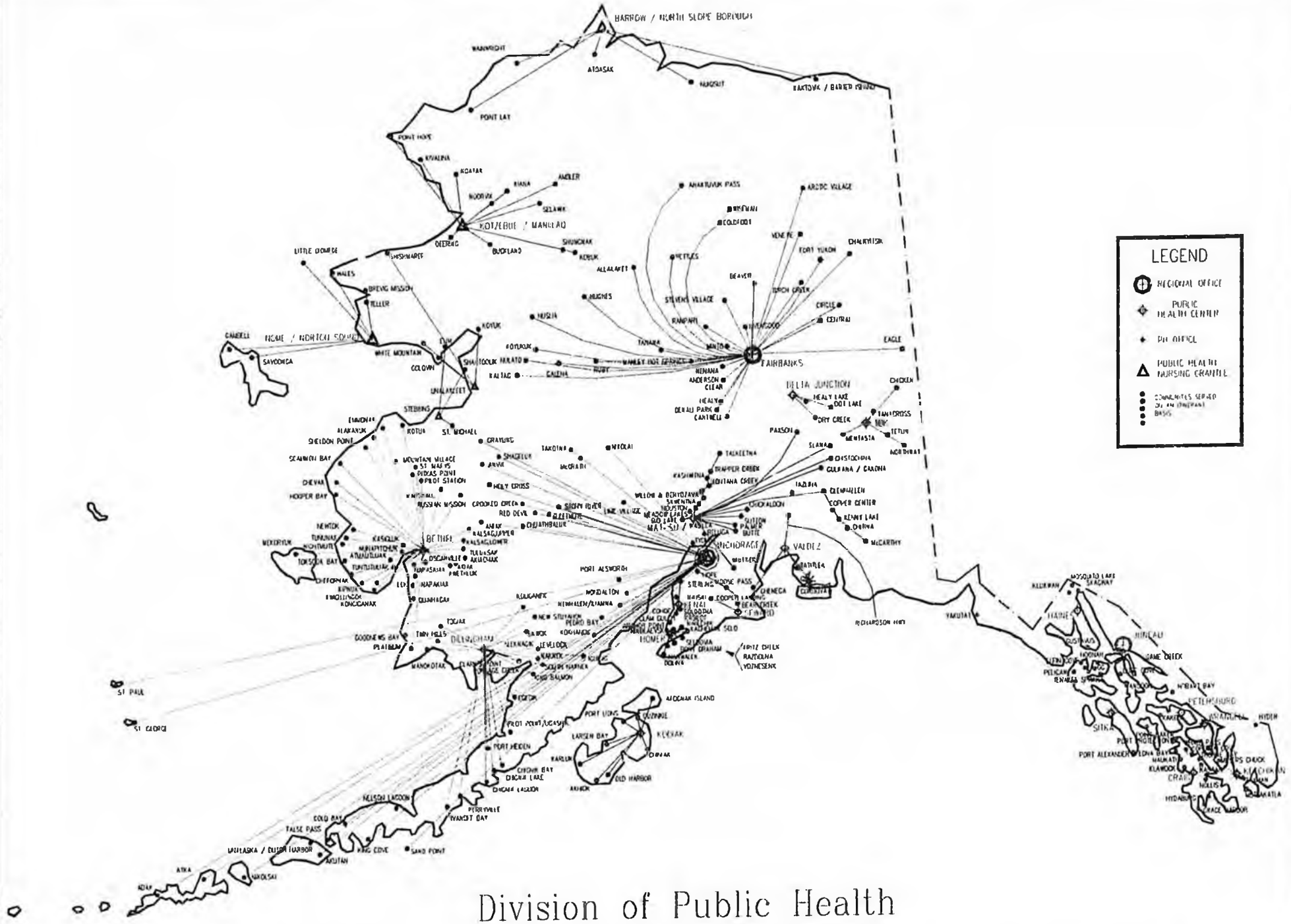

Division of Public Health
PUBLIC HEALTH NURSING

January, 2000

State of Alaska
Department of Health & Social Services

FY03 SERVICE REPORT

The public health nursing client services database does not break out services on an urban/rural designation. Public health nursing services data is tabulated by Public Health Center catchment area. Services provided to small villages and communities that are served on an itinerant basis by public health nurses are routinely tabulated within the statistics of the Public Health Center that serves as the home base of the itinerant public health nurse. We do not have an expedient means of breaking the data down into services provided in each individual community that is served on an itinerant basis. The number of communities served in each Public Health Center catchment area is indicated in parentheses after each health center name in the table below which show services provided in FY 03.

Site	Region	Undup # of Patients	# of Visits	0-19 y.o. Served	# Doses Vaccine	TB Tests	STD Patients	STD Visits	HIV Screens	HIV/AIDS Visits	Fam Plan Patients	Fam Plan Visits	Pap Smears
Fairbanks Health Center (37)	Interior	13,543	32,717	7,090	12,011	2,415	1,457	3,345	633	1,314	2,309	5,717	1,329
Ft. Yukon Health Center (1)	Interior	577	1,305	401	478	331	1	1	0	0	5	5	0
Galena Health Center (1)	Interior	947	1,256	662	623	738	1	1	0	0	1	1	0
Tok Health Center (8)	Interior	885	1,572	512	934	221	2	2	0	0	27	44	27
Glennallen Health Center (1)	Southcentral	575	789	278	477	268	7	9	0	0	9	23	0
Homer Health Center (13)	Southcentral	3,506	7,571	1,748	5,270	390	2	2	0	2	22	32	0
Kenai Health Center (8)	Southcentral	6,025	11,879	3,472	9,842	561	146	318	103	183	397	1,195	246
Cordova Health Center (4)	Southcentral	677	1,052	372	805	248	4	6	1	2	5	7	0
Matsu Health Center (24)	Southcentral	7,718	14,015	3,687	7,803	1,699	434	643	227	310	1,738	5,030	787
Seward Health Center (5)	Southcentral	949	1,668	495	1,168	87	32	48	15	27	165	450	108
Valdez Health Center (2)	Southcentral	2,035	2,932	618	2,585	477	0	0	0	0	2	2	0
Craig Health Center (7)	Southeast	1,834	3,294	940	1,301	1,546	25	40	21	31	94	280	30
Haines Health Center (4)	Southeast	983	1,619	505	938	266	10	26	16	24	90	264	28
Juneau Health Center ((9)	Southeast	4,318	8,991	2,196	3,934	1,612	572	850	470	725	1,221	2,738	671
Ketchikan Health Center (9)	Southeast	4,450	9,162	2,016	3,837	598	254	484	134	233	561	1,573	305
Petersburg Health Center (3)	Southeast	1,390	2,396	704	1,389	301	16	27	8	21	133	284	75
Sitka Health Center (2)	Southeast	1,383	1,988	715	1,726	137	76	137	26	97	57	71	8
Wrangell Health Center (2)	Southeast	1,284	2,118	613	1,297	427	24	33	9	19	105	278	40
Anchorage-based Intinerants (35)	Southwest	1,322	2,215	981	1,179	710	1	1	0	0	2	2	3
Bethel Health Center (40)	Southwest	10,300	14,127	7,698	8,310	6,353	795	1,145	149	311	394	517	503
Dillingham Health Center (22)	Southwest	2,704	3,780	1,895	980	1,875	42	54	4	6	62	97	35
Kodiak Health Center (8)	Southwest	2,697	5,355	1,212	3,822	498	79	130	48	92	416	1,422	189
Sub Totals		70,102	131,801	38,818	70,709	21,758	3,980	7,302	1,864	3,397	7,815	20,032	4,384
Grantees													
Barrow/NorthSlope PHN (6)		3,681	6,937	2,228	5,353	1,707	173	230	19	21	246	518	94
Kotzebue/Maniilaq PHN (12)		3,307	4,189	2,670	2,391	2,556	86	103	6	22	0	0	0
Nome/Norton Sound PHN (17)		6,531	14,420	3,689	7,433	3,896	345	591	14	48	73	109	20
TOTALS		83,621	157,347	47,405	85,886	29,917	4,584	8,226	1,903	3,488	8,134	20,659	4,498

The Municipality of Anchorage uses a different data and reporting system than the rest of the state. Their related data is reported below.

				# Visits	# Doses	(est)TB		STD	HIV			Fam Plan	Pap
		NA	NA	0-19 y.o.	Vaccine	Tests	NA	Visits	Screens	NA	NA	Visits	Smears
Municipality of Anchorage				6,404	9,237	3,656		4,586	2,129			7,686	2,220

Subject: [Fwd: testimony]
Date: Fri, 20 Feb 2004 07:56:56 -0900
From: Peggy Wilson <Representative_Peggy_Wilson@legis.state.ak.us>
Organization: Alaska State Legislature
To: Linda Miller <Linda_Miller@legis.state.ak.us>

Subject: testimony
Date: Fri, 20 Feb 2004 05:12:08 -0800 (PST)
From: laura roberts <finn310@yahoo.com>
To: Rep_Peggy_Wilson@legis.state.ak.us

Dear Rep. Wilson,
I've attached my testimony that I was unable to complete verbally at Tuesday's testimony. Thank you for allowing the submission of my testimony in writing. Sincerely, Laura Roberts

Laura Roberts
119 Austin St. #1202
Ketchikan, AK 99901

ANP Testimony.doc	**Name:** ANP Testimony.doc **Type:** WINWORD File (application/msword) **Encoding:** base64 **Description:** ANP Testimony.doc **Download Status:** Not downloaded with message

My name is Laura Roberts and I am a PHN although I am presently not working in this capacity. Currently, I work as a RN at the Ketchikan General Hospital and live on Prince of Wales Island. I worked on Prince of Wales Island as an Itinerant PHN at the Craig Public Health Center from 2000-2003. I was asked to provide testimony regarding the impacts of losing the State Advanced Nurse Practitioner position in this community. It was unfortunate that I was unable to provide this testimony verbally. But due to the weather and poor phone reception, I am submitting my testimony in writing for which I am most grateful to still be allowed to participate. Losing the ANP that provides some of the Women's Reproductive Health services offered by the state on Prince of Wales would have significant impacts at this point in time. I say "at this point I time" as I do believe Woman's Reproductive Services and Well Child Services could eventually be transitioned to qualified primary care providers (in the state of California only ANPs, Physician Assistants and MDs provide these services to women and children). During this future transition, I do believe some kind of PHN home visiting or case management program will first need to be strengthened in order to continue with the mission of educating, promoting health and providing resources to the high risk groups that PHNs serve. I greatly appreciate this opportunity and I hope I can cover the most pressing points, PHN follow up and case management and access, in my brief testimony.

Prince of Wales Island is currently struggling with the development of a health care system, as is evident by the monthly Health Care Advisory Committee meetings. Much of the discussion and planning surrounds the provision of primary, urgent, and emergent medical care of the population, not the provision of preventive care, such as the Family Planning, particularly to the uninsured, vulnerable population of teens and young women. Besides the Craig Public Health Center, SEARHC is the only other facility on the island that provides service on a sliding scale fee due to the HRSA grant they have been awarded. They also are the only provider of emergent care on the island, which coupled with medical management of illness and urgent care, to my understanding, keeps their primary care providers extremely busy. I do hope you have an opportunity to hear directly from them the nature of their clinic practice. There are two other medical providers, the Craig Clinic and Southeast OB/GYN. These providers, however, are fee for service and cost prohibitive for low income, uninsured women and especially teenagers. Also, Southeast OB/GYN visits monthly for one-two days. The Craig Public Health Center provides Women's Reproductive Health services to just over 90 clients, 39 of which are teenagers and a significant portion of the remaining fifty are young adult women who also demonstrate high risk behaviors. At this point, I think it is fair to say, that SEARCH may not have the time to provide family planning and follow-up of these at risk populations given their already full schedule and current personnel. Consequently, these clients will suffer greatly from losing the state ANP Women's Reproductive services, PHN follow-up and the severe reduction in access to these services.

Lacking PHN follow-up: PHN tracking and case-management in the Women's Reproductive Health program is vital to addressing not only family planning but many different public health issues within this high risk group. This core aspect of a public health focused program will be greatly compromised if the state ANP is lost. After the ANP has provided the initial and yearly woman's health exam, the PHNs follow-up with

these clients periodically to fill prescriptions and handle any problems with the chosen method of birth control. During a routine FP visit, the PHN may also screen for Domestic Violence, pregnancy and STDs, and educate and make referrals for smoking cessation, mental health, alcohol or drug use, nutrition and exercise. The routine FP visit with the PHN also becomes a prime opportunity to educate and promote health and prevent illness in a hard-to-reach, high risk group. In the unfortunate event of possible birth control failure, early access to pregnancy screening facilitates early access to Denali Kid Care and most importantly, early prenatal care. In 2002, the urine screen for Chlamydia and Gonorrhea became available and resulted in a higher number of teens and high risk men and women accepting this STD screening rather than the vaginal or penile swab that was required to obtain such a specimen. The ability to offer this screening will no doubt improve the early detection of these diseases, thus preventing their transmission and the morbidity sequela of PID and sterility. These are just two examples of the eternal justification for investing in public health services: The severity of long term costs of delayed detection or lack of treatment for community members far outweighs the immediate costs of providing screening and prevention for the community.

Access: In regards to access, the Craig Public Health Center is highly sensitive to the spontaneous visit of the adolescent family planning client. It is very frequent that teens will drop-in after school without an appointment requesting their method of birth control prescription be filled. It is not uncommon for young adult women clients to also request this short notice service. Without much delay, the Craig PHNs are able to either serve these clients on a drop-in basis or schedule appointments within a day or two after school hours. Of course, personal responsibility and planning are an on-going message of Public Health, however, behavior changes are incremental, and it only takes one-time of birth control method delay to result in unwanted and unplanned pregnancy. The SEARHC clinic has many urgent care demands during their drop-in hours and it isn't difficult to predict the access barriers a teen would face in such a busy medical practice. Furthermore, non-native beneficiaries are required to pay for all prescriptions at another local pharmacy, regardless of the HRSA grant thereby presenting another obstacle to low-income teens and young women. Additionally, the SEARHC clinic is in Klawock, seven miles from Craig, presenting another obstacle for many Craig teens and young woman who lack transportation. Access to the ECP would also decline if Family planning services were cut. In the past, SEARHC providers have referred women to the CPHC for this service as they have not provided this service.

Thank you for this opportunity to provide testimony. Sincerely, Laura Roberts