HB

337

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

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Sectional Analysis
HB 337, Version N, Health Care Transparency Act

Section 1

Provides for Legislative findings and intent to mandate an evaluation of the state's health care needs, propose reforms, and improve health care in Alaska by establishing the Alaska Health Care Commission for the purpose of developing a comprehensive policy that better meets the current and long-range health care needs in the state.

Sec. 2 AS 18.05.010(b)

Requires the Department of Health and Social Services to implement a statewide health plan under AS 18.09, which is a new chapter creating the Alaska Health Care Commission.

Sec. 3 AS 18.07.031(e)

Amends definition of "expenditure" under the Certificate of Need program.

Sec. 4 AS 18.07.111(8)

Under the Certificate of Need program, applies the definition of "health care facility," if the hospital facility, or center is located in a municipality or borough that has a critical access hospital or that has a population of 60,000 or fewer persons (excluding recipients of military or Indian Health Service health care); and nursing homes, residential psychiatric treatment centers; excludes Alaska Pioneers Homes, offices of private physicians or dentists, and military and tribal health entities.

Sec. 5 AS 18.07.111

Amends definitions of facilities in which Certificate of Need applies, including: ambulatory surgical facility, critical access hospital, independent diagnostic testing facility, intermediate care facility, kidney dialysis center, nursing home, office of private physicians (50 percent owned and operated by physicians), and psychiatric hospital.

Sec. 6 AS 18

Adds new **Chapter 9**, Statewide Health Information Office; **Article 1**.
Sec. 18.09.100 Establishes an Alaska Health Care Information Office in the Department of Health and Social Services to provide consistently updated health care facility information to aid consumers of health care services, and information to encourage personal responsibility in prevention and healthy living.

Sec. 18.09.110 Requires the department to establish and maintain a database on an Internet website about health care facilities services and cost. Information in the data base includes health care facility information; health care providers licensed in Alaska; a list of not more than 1500 commonly prescribed medications in the state and the cost; a list

of not more than 250 most commonly conducted medical procedures in the state and the cost; hospital ratings; consumer education information on health, insurance information, clinics that cater to uninsured and self-pay patients; and quality of health care facilities; and information regarding prevention and healthy living.

Sec. 18.09.120 Requires health care facilities to provide the department information related to the facility's health care services for placement on the database developed under AS 18.09.110.

Sec. 18.09.130 The Department of Administration, the Department of Commerce, Community and Economic Development, and the Department of Labor and Workforce Development, and the Department of Law shall provide information for placement on the database regarding adverse actions taken against a health care facility or against licensed professionals practicing in health care facilities in the state and cooperate with the department in performance of its duties under AS 18.09.100- 18.09.130.

Article 2
Sec. 18.09.900 Allows the Department of Health and Social Services to adopt regulations under AS 44.62 to carry out purposes of this chapter.

Sec. 18.09.990 Provides definitions of facilities from which the department would collect information.

Sec. 7

Establishes a 16-member Alaska Health Care Commission within the Department of Health and Social Services. The purpose of the Commission is to consider the spectrum of health care related issues and formulate policy recommendations to be presented to the legislature and executive branch; to develop a statewide plan to address the quality, accessibility and affordability of health care for all citizens of the state; to provide an annual report to the legislature that includes a comprehensive list of policy options considered by the commission; and to review and approve facility health care information for placement on the department's Internet database established under AS 18.09.110.

Section 2 also specifies that the plan contain a health care policy and a strategy for encouraging: personal responsibility and reductions in health care costs; access to safe water and wastewater systems; development of a sustainable health care workforce; accessible quality health care; and an increase in the number of residents who are covered by insurance.

Membership of the commission includes the department medical director (chair), a representative of the Mental Health Trust Authority appointed by the authority, a representative of the University of Alaska health education and training programs appointed by the university; seven public members including: one member representing the Alaska Native Tribal Health Consortium appointed by the consortium, one member

representing the Alaska Primary Care Association appointed by the association, one member representing the Alaska State Nurses Association appointed by the association, one member representing the health insurance industry appointed by the governor, two health care consumers or advocates appointed by the governor, one of whom will be a small business owner in the state; six members of the legislature, three appointed by the president of the senate and three appointed by the speaker of the house of representatives. Terms of office are staggered terms of three years.

The commission shall employ an executive director who is not a member of the commission: and is classified as partially exempt.

The Health Care Commission sunsets June 30, 2014.

Sec. 8

Directs the commissioner of the Department of Health and Social Services and Department of Law to immediately take steps to seek dismissal of pending administrative appeals and court actions concerning the issuance of certificates of need, as appropriate, under AS 18.07, as amended.

Sec. 9

Allows the Department of Health and Social Services to adopt regulations necessary to implement changes made by this Act.

Sec. 10

Provides for the department of contract with an entity to conduct a comprehensive study of the effects of the certificate of need program in the state, and provide a copy of the study to the legislature.

Sec. 11

Section 9 takes effect immediately (for the development of regulations).

Sec. 12

Except as provided in sec. 11, the Act takes effect July 1, 2008.

Changes in the CS for House Bill 337, N amended

HB337 original	HB 337 CS, Version N, amended
Creates **Health Care Commission** to review health care policy and develop a plan – 10 members • DHSS Med. Officer (Chair) • DOA rep • DCCED rep • DOL rep • 3 public members (1 small business owner) • House ex-officio, • Senate ex-officio, • Gov. office ex-officio July 1 effective date	**Section 7:** **Page 9 lines 10 - page 10, line 6** Changes composition of the **Health Care Commission: 16** members: • DHSS Med. Director (Chair) • **MHTA (appointed by MHTA)** • **UA health ed (appointed by UA)** • 7 public members o **ANTHC (appointed by ANTHC)** o **AK Primary Care Assoc (appointed by Assoc)** o **AK St. Hosp. & Nursing (appointed by Assoc)** o **Health Ins. (Gov appointed)** o **AK Nurses Assoc. (appointed by Assoc)** o **2 health care consumers (1 small business owner) (appointed by Gov.)** • **6 members of legislature** o 3 House representatives o 3 Senate representatives **Commission sunsets June 30, 2014**
Creates **Health Info office**: health info on web site on health care facilities, costs on health care, licensed facilities, July 1 effective date	**Section 6:** **Pages 5-7** Modifies info gathered to focus on: • Access to health care, • Cost of health care , **update monthly** • **Up to 1500 common prescribed med.** • **Up to 250 common medical procedures** • Quality of health care • **Hospital ratings including infections and mortality** • **Consumer education info on topics** • **Prevention and healthy living info**
Repeals Certificate of Need, immediate effective date	**Section 3,4:** **Pages 3- 5** • Retains CON statewide EXCEPT for municipality or borough of 60,000 or more: (Anchorage, Mat-Su, Fairbanks) • EXCEPT retains CON statewide for: • Nursing Homes • RPTC • Adds statutory definitions for health care facilities that are subject to CON • Exempts federally funded or operated military and Tribal health facilities • DHSS conduct study effects of CON program **Effective July 1, 2008**

4/5/08

Alaska Health, Education & Social Services Committee

Testimony on Certificate of Need

by

Robert James Cimasi
MHA, ASA, CBA, AVA, CM&AA, CMP

January 29, 2008

ONLINE

Testimony Related to Alaska House Bill 337: *An Act establishing the Alaska Health Care Commission and the Alaska Health Care Information Office; relating to healthcare planning and information; repealing the certificate of need program for certain healthcare facilities; and providing for an effective date"*

January 31, 2008

By Robert James Cimasi, MHA, ASA, CBA, AVA, CM&AA, CMP

Good afternoon Madam Chair and Members of the Alaska House of Representatives. Thank you for the opportunity to speak before the Alaska House Health Education & Social Services Committee regarding the proposed House Bill 337: "*An act establishing the Alaska Health Care Commission and the Alaska Health Care Information Office; relating to healthcare planning and information; repealing the Certificate of Need program for certain healthcare facilities; and providing for and effective date.*[1]"

My name is Robert James Cimasi. I am President of Health Capital Consultants, a national healthcare economic and financial consulting firm located in St. Louis, MO. On August 16, 2001, I was appointed to serve on the Acute Care Focus Group of the Missouri Certificate of Need Technical Advisory Committee (CONTAC) for the Missouri Health Facilities Review Committee (MHFRC). Over the past few years my firm has conducted dedicated, focused research resulting in a comprehensive reference manual & sourcebook encompassing the statutory, regulatory, administrative, and legal aspects of Certificate of Need (CON) regulation from its inception in the late 1960's to the present. Elements of this research on CON were published in December 2005, as *"The U.S. Healthcare Certificate Of Need Sourcebook"* which summarizes numerous studies, monographs, and research reports regarding CON regulations, as well as, law review, bar journal articles, and in excess of 700 published legal cases related to CON. Attached to your handouts is a brief description of my professional qualifications.

Over the years, the scope of my professional activities including testimony in court, before legislative, and agency hearings, has required and permitted me and my firm to conduct extensive research and analysis in the areas of healthcare delivery, public health planning, healthcare economics, and market competition; as well as, other Certificate of Need (CON) related topics. Based on these activities and experiences, it is my informed view that this committee should vote to advance House Bill 337 (hereinafter referred to as the PROPOSED BILLS).

CON is a failed public health policy which is bad for Alaska citizens and patients for several key reasons. The following topics should be addressed:

1. **CON's History as A Failed Health Planning Policy;**
2. **The Effects of CON Repeal in Several States;**
3. **The Federal Trade Commission's Repeated Denunciation of CON;**
4. **CON Has Failed to Lower Healthcare Costs;**
5. **CON is Anti-competitive;**

[1] Health Care Plan/Commission/Facilities by Alaska House of Representatives , Alaska House of Representatives, January 2008, http://www.legis.state.ak.us/basis/get_bill.asp?bill=HB%20337&session=25 (2008)

6. **CON is a Barrier to Healthcare Innovation;**
7. **CON Reduces Access and Patient Choice; and,**
8. **CON Hasn't Improved Healthcare Quality.**

Testimony Related to Alaska House Bill 337: *An Act establishing the Alaska Health Care Commission and the Alaska Health Care Information Office; relating to healthcare planning and information; repealing the certificate of need program for certain healthcare facilities; and providing for an effective date"*

1. CON's History as Failed Health Planning Policy

CON legislation was put in place nationally as a result of a Federal mandate in 1974. Based on over three (3) decades of experience, it is now clear that the CON process does not offer the better, more efficient solution to reducing healthcare cost that its proponents have proudly proclaimed. As Duke Professor of Law Clark Havighurst concludes "*Protectionist regulation, long discredited in other areas, is particularly misguided in healthcare, where health insurance greatly increases the profitability of monopoly and imposes the resulting higher costs on unwilling premium payers. To use cross-subsidies to finance even worthy (let alone unworthy) health care projects is to put public burdens unfairly (regressively) on the backs of working Americans.*"[2]

By 1986, the federal government had shifted its attitude toward CON regulation. Over a decade later, the federal CON legislation previously passed in 1974 had failed. The National Health Planning Act was repealed due to *"mounting empirical evidence that certificate of need cost containment objectives were not being realized."*[3]

Instead, the application of CON regulation has only encouraged erroneous outcomes, to the detriment of Alaska's public interest, on the basis of insufficient valid data, flawed methodology, arbitrary and capricious standards, and the ambiguity of unrestricted agency discretion in an atmosphere of political influence. The Alaskan CON process' almost total lack of applicable, valid empirical data; the absence of generally accepted methodological standards of economic and financial analysis, and the lack of consideration of all required pertinent variables, are based on statutes and rules that are so fatally flawed and so clearly based on arbitrary and capricious standards as to be unreasonably burdensome on the citizens and patients of Alaska. Your passage of House Bill 337 would relieve this onerous situation.

2. Effects of CON Repeal

The Joint Legislative and Audit Review Committee and the Health Policy Analysis Program of the University of Washington's School of Public Health and Community Medicine published a study of the certificate-of-need program in the state of Washington on January 8, 1999. The results of this study are published as the "*Effects of Certificate of Need and Its Possible Repeal*". This meta-study, one of the most comprehensive efforts recently conducted in the area of CON, *"examined the effects of CON and its possible repeal on the cost, quality, and availability of five health services – hospitals, ambulatory surgery, kidney treatment, home health, and hospice – as*

[2] "Monopoly Is Not The Answer," By Clark C. Havighurst, Health Affairs, August 9, 2005.
[3] *See* Aaron S. King, *Medical Market Failure in Maine: Is the Dirigo Reform Act's Certificate of Need a Market Correction?*, 22 Me. B.J. 156 (2007).

well as on charity care and health services in rural areas."[4] esults of this study were based on literature review, interviews, and information from healthcare providers and healthcare economic experts in the State, as well as an analysis of eight (8) states which completely or partially repealed their CON laws (i.e. Arizona, Indiana, Ohio, Pennsylvania, Tennessee, Texas, Utah, and Wisconsin).[5] The study found that CON *"has not controlled overall healthcare spending or hospital costs."* It also found *"conflicting or limited evidence about the effects of CON on the quality and availability of other healthcare services or about the effects of repealing CON."*[6]

The study does not predict the effects of CON repeal; however, the study reflected that CON has been shown to restrict the supply of some specific health services in some areas, and inferred that, perhaps as a result, supply surges occurred in some specific health services of some areas.[7] Some supply surges were experienced in psychiatric hospitals and nursing homes (Utah); nursing homes and open heart surgery (Arizona); home health (Tennessee); hospitals, ambulatory surgery centers, dialysis, and pediatric services (Ohio); hospitals and psychiatric hospitals (Wisconsin) and nursing homes and psychiatric hospitals (Texas) after the repeal of CON.[8] These finding were not consistent in every state that completely or partially repealed their CON laws that was included in the Washington study.

> *"Not all states experience surges after repeal. When surges do occur, they tend to moderate over time"...In addition, initial surges are sometimes followed by periods of shakeout and stabilization. Therefore, while short term supply increases do appear at times after CON repeal, such surges have been insufficiently studied to determine if there are any persistent effects on cost (or on other goals such as quality and access).*[9]

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[4] "Effects of Certificate of Need and Its Possible Repeal", Joint Legislative and Audit Review Committee and the Health Policy Analysis Program of the University of Washington's School of Public Health and Community Medicine, Jan. 8, 1999, p. i.

[5] "Effects of Certificate of Need and Its Possible Repeal", Joint Legislative and Audit Review Committee and the Health Policy Analysis Program of the University of Washington's School of Public Health and Community Medicine, Jan. 8, 1999, p. ii, 6.

[6] "Effects of Certificate of Need and Its Possible Repeal", Joint Legislative and Audit Review Committee and the Health Policy Analysis Program of the University of Washington's School of Public Health and Community Medicine, Jan. 8, 1999, p. iii.

[7] "Effects of Certificate of Need and Its Possible Repeal", Joint Legislative and Audit Review Committee and the Health Policy Analysis Program of the University of Washington's School of Public Health and Community Medicine, Jan. 8, 1999, p. 10.

[8] "Effects of Certificate of Need and Its Possible Repeal", Joint Legislative and Audit Review Committee and the Health Policy Analysis Program of the University of Washington's School of Public Health and Community Medicine, Jan. 8, 1999, p. 13.

[9] "Effects of Certificate of Need and Its Possible Repeal", Joint Legislative and Audit Review Committee and the Health Policy Analysis Program of the University of Washington's School of Public Health and Community Medicine, Jan. 8, 1999, pp. 11, 13.

A 1998 empirical study, which examined health spending between the late 1970's and 1993 and looked at spending prior to and directly after state CON laws were repealed, stated:

> *"The major findings about CON can be summarized as follows: first, we found no surge in expenditures after CON was lifted; second, despite a statistically significant reduction by mature programs on acute spending per capita, there was no corresponding reduction in total per capita spending (apparently due to offsetting expenditures on non-hospital services)...We found that mature CON reduced hospital bed supply per capita population, but could detect no increase in bed supply following the removal of CON.*[10]

Further, the study authors found that established CON programs increased cost per adjusted patient day and also cost per admission.

According to a Conover and Sloan 1998 study, there was no empirical support that CON saved any money. Further, researchers concluded "There is no evidence of a surge in acquisition of facilities or in costs following removal of CON regulations . . . CON regulations generally have no detectable effect on diffusion of various hospital-based technologies. It is doubtful that CON regulations have had much of an effect on quality of care, position of negative."[11] Experts have surmised that CON may increase the cost of health care. Administrative costs associated with state-level oversight and litigation expenses increase to the costs.[12] This is compounded by the problem that the CON approval process is highly technical in nature.

3. The Federal Trade Commission's Repeated Denunciation of CON;

3.1 FTC and DOJ Joint Hearings and Report on Healthcare Competition and CON

In November 2002, FTC Chairman, Timothy J. Muris, announced that the FTC would hold joint hearings with the DOJ on competition in healthcare in 2003.[13] On July 23, 2004, following the conclusion of the hearings lasting over six (6) months, the FTC and DOJ (agencies) issued a joint report on July 23, 2004, entitled "*Improving Health Care: A Dose of Competition*" in which the agencies recommended that states decrease barriers to entry into provider markets. The agencies encouraged states to reconsider whether CON programs *"best serve their citizens' health care*

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[10] "Does Removing Certification-of-Need and Regulations Lead to a Surge in Health Care Spending?" Conover, Christopher J., Sloan, Frank A., Journal of Health Politics, Policy and Law, vol. 23, no. 3, June 1998, p. 455

[11] Christopher J. Conover, Frank A. Sloan, *Does Removing Certificate of Need Regulations Lead to a Surge in Health Care Spending?*, 23 J. HEALTH POL. POL'YY & L. 455 (1998).

[12] *See* Aaron S. King, *Medical Market Failure in Maine: Is the Dirigo Reform Act's Certificate of Need a Market Correction?*, 22 Me. B.J. 156 (2007).

[13] "FTC Chairman Announces Public Hearings on Health Care and Competition Law and Policy to Begin in February 2003" Federal Trade Commission, www.ftc.gov/opa/2002/11/murishealthcare.htm. (Accessed Aug. 5, 2004).

needs".[14]

Following testimony at numerous hearings from industry representatives and legal, economic, and academic experts on the healthcare industry and health policy, the agencies concluded that the burdens placed on competition by CON programs "*generally outweigh*" its "*purported economic benefits*". *The agencies suggested that instead of reducing costs, there is evidence that CON programs actually drive up costs by "fostering anticompetitive barriers to entry".*[15]

The agencies expressed concern that CON programs raise healthcare costs because they appear to be used to shield healthcare providers from competition. The agencies expressed further concern that CON programs tend to prevent entry into the market by enterprises that may be able to provide higher quality care, and the report contended that CON programs may delay the introduction of new technology. In support of their conclusions, the agencies relied upon empirical studies that showed CON programs generally failed to control costs and actually appear to result in higher healthcare costs.[16]

Subsequent to the FTC's July 23, 2004 report, on May 24, 2005 , the FTC delivered a statement before the SubCommittee on Federal Financial Management, Government Information, and International Security of the Committee on Homeland Security and Governmental Affairs, U.S. Senate on New Entry Into Hospital Competition, the agency stated , " *vigorous competition can have important benefits in the hospital arena, just as in the multitude of markets in the U.S. economy that rely on competition to maximize the welfare of consumers. Competitive pressures can lead hospitals to lower costs, improve quality and compete more efficiently. Competitive pressures also may spur new types of competition. In hospital markets, some new entrants specialize and prove only a limited portion of the in-patient and out-patient services that general hospitals tend to provide."*[17] Specifically, the FTC testimony emphasized that, "*Overall, testimony at the FTC/DOJ Hearings identified a number of benefits that SSHs [single specialty hospitals] may offer to consumers, with no significant controversy about the potential for SSHs to provide those benefits. Rather, as discussed in more detail below, debate about SSHs generally centered on how they may affect the functioning of general hospitals."*[18] Ultimately, the FTC testimony related to the efficacy of CON concluded that,

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[14] "Improving Health Care: A Dose of Competition" A Report by the Federal Trade Commission and the Department of Justice, July 2004, Executive Summary, p. 22.

[15] "Improving Health Care: A Dose of Competition" A Report by the Federal Trade Commission and the Department of Justice, July 2004, ch. 8, pp. 1-2.

[16] "Improving Health Care: A Dose of Competition" A Report by the Federal Trade Commission and the Department of Justice, July 2004, ch. 8, p. 4.

[17] Prepared Statement of the Federal Trade Commission Before the SubCommittee on Federal Financial Management, Government Information, and International Security of the Committee on Homeland Security and Governmental Affairs, U.S. Senate on New Entry Into Hospital Competition, May 24, 2005, p. 3.

[18] Prepared Statement of the Federal Trade Commission Before the SubCommittee on Federal Financial Management, Government Information, and International Security of the Committee on Homeland Security and Governmental Affairs, U.S. Senate on New Entry Into Hospital Competition, May 24, 2005, p. 8.

> *"The Commission believes that CON programs generally are not successful in containing health care costs, and that they can pose anticompetitive risk. As noted above, CON programs risk entrenching oligopolists and eroding consumer welfare. The aim of controlling costs is laudable, but there appear to be other, more effective means of achieving this goal that do not pose anticompetitive risks. Indeed, competition itself is often the most effective method of controlling costs. A similar analysis applies to the use of CON programs to enhance health care quality and access."*[19]

These Federal findings, by the FTC and DOJ, are only one of the significant pronouncements in the last several years that support the rational justification to eliminate CON and support a level playing field for providers in fostering *"a dose of"* market competition in healthcare.

3.2 Previous FTC Studies of CON

The FTC's unfavorable review of CON as a failed health policy planning mechanism is not a new event. Beginning in the late 1980s, the FTC issued several studies on CON and stated that, *"Market forces generally allocate society's resources far better than decisions of government planners."*[20]

3.3 The FTC's Recommendations That States Repeal CON

The FTC has consistently recommended that the states remove their CON regulations. In a 1987 letter to Virginia officials they stated, *"Any potential benefits of CON regulation are likely to be outweighed by the adverse effects of such regulation on competition in health care markets. Consequently, CON regulation is likely to harm consumers on balance by increasing the price, and decreasing the quality, of health services in Virginia."*[21] The FTC has issued similar statements before numerous states considering the repeal of CON laws.

4. CON Has Failed To Lower Healthcare Costs

After nearly thirty (30) years of study, the preponderance of healthcare economic analysis has clearly indicated that CON laws have failed to achieve their stated objectives. In an article reviewing CON laws and their application to modern markets, Patrick J. McGinley, Esq. wrote, *"In searching the scholarly journals, one cannot find a single article that asserts that CON laws*

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[19] Prepared Statement of the Federal Trade Commission Before the Subcommittee on Federal Financial Management, Government Information, and International Security of the Committee on Homeland Security and Governmental Affairs, U.S. Senate on New Entry Into Hospital Competition, May 24, 2005, p. 18.
[20] Press Release from the Federal Trade Commission, Aug. 10, 1987
[21] Press Release from the Federal Trade Commission, Aug. 10, 1987

succeed in lowering healthcare costs."[22]

In fact, a 2003 study headed by David C. Grabowski entitled *"The Effects of CON Repeal on Medicaid Nursing Home and Long-Term Care Expenditures"* found no significant increase in either nursing home or long-term care Medicaid expenditures in states that repealed their CON and moratorium laws.[23]

This confirmed the findings of an earlier 1998 study by Christopher J. Conover and Frank A. Sloan that mature CON laws resulted in a "*two percent (2%) reduction in bed supply but higher cost per-day and per admission, along with higher hospital profits.*"[24]

Additionally, a recent report commissioned by, and presented to the Georgia CON Commission by William S. Custer, Ph.D., entitled, "*Report of Data Analysis to the Georgia Commission on the Efficacy of the CON Program*," dispels many of the continuing myths propounded by CON advocates which assert that CON controls healthcare costs. Dr. Custer described his findings related to the overall strategy of CON regulation as the management of the allocation of health care resources and prevention of the duplication of services by creating artificial barriers to market entry, resulting in monopoly of players already present in the market.[25] Further, in response to the Georgia Commission's request for Dr. Custer to study the efficacy of CON, Dr. Custer concluded that, contrary to the purpose of CON, basic economic theory suggests that monopolies generally have higher process and lower quality than firms in more competitive markets.[26]

Although one of the original purposes of CON was to restrict supply of hospital beds and services, the authors concluded that there does not seem to be a statistically significant correlation between a lower number of hospitals or hospital bed supply and the presence of CON regulation in the acute setting.[27] Of the states studied, while Georgia experienced the most rapid growth in the number of ambulatory surgery centers, it is important to highlight that the study

[22] "Beyond Health Care Reform: Reconsidering Certificate of Need Laws In a Managed Care Competition System", McGinley, PJ , Florida State University Law Review, 1995.
[23] "The Effects of CON Repeal on Medicaid Nursing Home and Long-Term Care Expenditures", Grabowski, David C., Ohsfeldt, Robert L., Morrisey, Michael A., Inquiry-Excellus Health Plan, vol. 40, no. 2, Summer 2003, p. 147.
[24] "Does Removing Certification-of-Need and Regulations Lead to a Surge in Health Care Spending?" Conover, Christopher J., Sloan, Frank A., Journal of Health Politics, Policy and Law, vol. 23, no. 3, June 1998, pp. 463, 466.
[25] "Report of Data Analysis to the Georgia Commission on the Efficacy of the CON Program," By William S. Custer, Ph.D. et al, October 2006, p.5.
[26] "Report of Data Analysis to the Georgia Commission on the Efficacy of the CON Program," By William S. Custer, Ph.D. et al, October 2006, p.5.
[27] "Report of Data Analysis to the Georgia Commission on the Efficacy of the CON Program," By William S. Custer, Ph.D. et al, October 2006, p.7.

found that there was "***not a statistically significant relationship between CON rigor and the number or growth of ASCs.***"[emphasis added].[28]

Recently, the proponents of CON have suggested that CON is necessary to protect charity care provided by community hospitals. However, this assertion has been strongly rebuked. Recently, a working paper prepared by the FTC concluded that, "*Most noticeable in all of the results is the lack of any statistically significant evidence for the cross-subsidization hypothesis. The data provides no statistically significant evidence that increased competition leads to reductions in charity care. The claim that hospitals will use market power to increase services to the poor is largely unsupported by this data.*"[29]

As stated by Clark C. Havighurst, a William Neal Reynolds Professor Emeritus of Law at Duke University School of Law, *"The huge enterprises that U.S. hospitals have become are largely unaccountable for the amounts of revenue they raise or the uses to which they put that money. Indeed, they are major contributors to ever-rising healthcare costs. Using CON regulation to maintain their ability to extract resources from the economy only to pour them back into more health care would keep costs under control. Competition is the best way both to limit dominant hospitals' claims on gross domestic product (GDP) and to restore voters and their representatives the power to decide just what extras are worth paying for."*[30]

Aside from its ineffectiveness in reducing costs and its inability to promote charity care, CON itself incurs large administrative and indirect costs as an added burden on available healthcare funding. As Christopher J Conover, an assistant research professor with the Center for Health Policy, Law and Management in the Terry Sanford Institute of Public Policy at Duke University, recently stated, "*There is a significant amount of literature on the benefits and costs of regulation in the U.S. economy, with the first efforts to estimate the overall impact dating back to the mid-1970s. From this work it is known that regulations impose a considerable burden on U.S. businesses and consumers: the impact of regulation on the overall economy will approach $1 trillion in 2004.*" Specifically, Conover found that, CON regulations had a net cost of approximately $110 million, with no value to consumers. "*The most recent studies that use the most credible statistical methods and most recent data find no impact of CON regulation on health spending (and concomitantly no increase in health spending among states that have elected to drop CON regulation), so zero was used as the expected value.*"[31] The cost of attorneys, consultants, lobbyists and internal staff to healthcare organizations for CON

[28] "Report of Data Analysis to the Georgia Commission on the Efficacy of the CON Program," By William S. Custer, Ph.D. et al, October 2006, p.8.
[29] "Hospital Competition and Charity Care," Working Paper No. 285By Christopher Garmon, Bureau of Economics Federal Trade Commission, October 2006, p.18.
[30] "Monopoly Is Not The Answer," By Clark C. Havighurst, Health Affairs, August 9, 2005.
[31] "Health Care Regulation A $169 Billion Hidden Tax," By Christopher J. Conover, Policy Analysis, No. 527, CATO Institute, October 4, 2004, pp.2, 8.

applications is considerable. Litigation and lobbying on both sides of the CON debate are other significant costs.

CON was originally conceived in the old payment structure plan of fee for service. With the advent of managed-care and the sea change it has brought to healthcare, CON is more useless now than ever. CON has devised what economist call the "Roemer Effect" which essentially means if there is a hospital bed to be filled, doctors will find a way to do so to increase their revenue. Yet managed care, with capitation payment schemes, has eliminated the "Roemer Effect" and the incentive to provide unnecessary or "duplicative" services. Physicians and hospitals are under pressure to constrain and control their expenses, not balloon them.[32]

5. CON is Anti-competitive

Competition creates choices for consumers and raises quality standards as providers compete for patient loyalty. A 1993 study found that hospitals in more competitive markets had average costs below those of less competitive markets.[33] According to Professor Carolyn Madden, *"[T]here is ... agreement across all perspectives of [health economics theory] on one issue: the negative consequences of too much concentration of economic power."*[34]

The evidence presented by Ellen S. Campbell and Gary M. Fournier in their 1993 study entitled, *"Certificate-of-Need Deregulation and Indigent Hospital Care,"* commented on CON's anticompetitive effect, in suggesting that overall CON policy is absent of a *"clear, economic, and legal standard to distinguish between an action to deny an applicant in order to prevent investments that would raise costs by unnecessary duplication, and actions motivated by the anticompetitive effect of such denial...[T]he trouble is that agency decisions can often accomplish the latter while claiming the former."*[35]

As Duke Professor of Law Clark Havighurst concludes, *"But CON regulation was itself not clearly intended to suppress competition that is inconvenient for certain hospitals. Ostensibly, at least, the original rationale for enacting CON laws in the regulation-ridden 1970s was policymakers' belief that market forces could not be trusted to defer overinvestment in health facilities. Since that time, cost reimbursement have been replaced by prospective payment (even for capital expenditures), removing a major cause of the problem that first occasioned CON regulation. In addition, private health plans have developed the ability to steer patients to cooperative, low –cost providers, thereby signifying a "need" for the latter's facilities and*

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[32] *See* Aaron S. King, *Medical Market Failure in Maine: Is the Dirigo Reform Act's Certificate of Need a Market Correction?*, 22 Me. B.J. 156 (2007).

[33] "California Providers Adjust To Increasing Price Controls", Zwanziger J, Melnick G, Bamezai A., Health Policy Reform: Competition and Controls, AEI Press, 1993, pp. 241-58.

[34] Madden CW. "Excess capacity: markets, regulation, and values." Health Services Research. February, 1999.

[35] "Certificate-of-Need Deregulation and Indigent Hospital Care", Campbell, Ellen S., Fournier, Gary M., Journal of Health Politics, Policy and Law, vol. 18, no. 4, Winter 1993, pp. 922-923.

services and belying the old notion that supply can create its own demand. Thus, whatever, might have been the case in the earlier era, it is far from obvious today that CON regulation is needed to avoid excess capacity."[36]

Market competition in healthcare delivery provides economic empowerment to patients and payors by providing access; encouraging innovation and the investment of capital in overall cost saving technologies; and, by creating choices for consumers which, in turn encourages providers to raise quality standards as they compete for patient loyalty. When patient choice is diminished, decisions about appropriate pricing/costs, access, quality, and beneficial outcomes become the sole purview of elite groups of oligopoly decision makers who, in the absence of healthy competition, are free to ignore market demands and patient needs. That circumstance is what drives the acceleration of costs.

6. CON is a Barrier to Healthcare Innovation

Because CON acts as a barrier to entry for new market entrant competitors, it slows the introduction of new healthcare facilities, equipment, and services and thus acts as a barrier to healthcare innovation. Famed economist Michael Porter wrote in the Harvard Business Review:

> *"In industry after industry, the underlying dynamic is the same: competition compels companies to deliver increasing value to customers. The fundamental driver of this continuous quality improvement and cost reduction is innovation. Without incentives to sustain innovation in healthcare, short-term cost savings will soon be overwhelmed by the desire to widen access, the growing health needs of an aging population, and the unwillingness of Americans to settle for anything less than the best treatments available. Inevitably, the failure to promote innovation will lead to lower quality or more rationing of care – two equally undesirable results."*[37]

CON repeal would remove unnecessary and irrational constraints and costly regulatory barriers to innovation; to investment in new technologies; to quality services; and, to cost-effective improvements, which, as the technology of healthcare advances, offer the true and valid opportunity to provide cost-effective quality healthcare to Alaska's citizens.

7. CON Reduces Access and Patient Choice

The fundamental and simplistic, yet flawed, idea of CON was straightforward: lower costs by "reducing duplication". However both competition and patient choice, by definition, require "duplication" of providers. Denial of patient choice in Alaska is tightly correlated with the barrier to entry posed by CON. New medical provider entrants, no matter how efficiently and

[36] "Monopoly Is Not The Answer," By Clark C. Havighurst, Health Affairs, August 9, 2005.
[37] "Making competition in health care work." By Michael Porter, et al. Harvard Business Review, July/Aug. 1994, p. 131.

creatively they might contribute to higher quality, more beneficial outcomes, and lower overall healthcare costs, face substantial opposition by these established oligopoly interests, who, historically, have actively strived to limit competition with the resulting impact of denying patient choice for Alaskans and their families.

Excess capacity is a value-laden term, not an absolute standard. In a February 1999 article published in Health Services Research, Professor Carolyn Madden summarized a number of studies of excess capacity saying, *"Without a clear statement of this standard [e.g., the correct number of hospital beds], we cannot determine what constitutes too many. The research literature provides no clear statement."*[38]

Access issues are especially important in rural areas where patients must travel long distances and have little choice of provider. Access is closely linked to patient choice. When choice is diminished, decisions about access, quality, and beneficial outcomes are made in isolation by healthcare businesses. In the absence of healthy competition, they are free to ignore patient needs and demands.

Under CON laws, patients are *de facto* limited to accept the services that existing providers wish to offer them when making major healthcare decisions for themselves and their families because their geographic region may be determined by CON administrators to lack a sufficient utilization ratio to allow alternative market entrants.

8. CON Hasn't Improved Healthcare Quality

CON proponents, faced with irrefutable empirical data and evidence that CON has utterly failed, now have attempted to shift their ever-changing arguments to a new focus, that CON protects quality. They claim that by limiting the number of locations for highly technical surgeries and procedures, that each location and surgeon gains a greater level of experience with these procedures, which results in better quality outcomes. Part of this argument by CON proponents is based on the disingenuous quoting of research from *"The Dartmouth Atlas of Healthcare"* which does not support this assertion. Further, there have been a number of studies which contradict these assertions.[39] An article, in the March 2003 issue of Health Affairs entitled, *"Why Competition Law Matters To Health Care Quality"* once again refutes the validity of these CON proponents latest desperate move to maintain this failed policy.[40]

Healthcare economists know that in the absence of sustained competition, large provider systems have little or no incentive to offer the highest quality at the lowest price. Effective health policy

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[38] Madden CW. "Excess capacity: markets, regulation, and values." Health Services Research. February, 1999.
[39] "Is volume related to outcome in health care? A Systematic review and methodologic critique of the literature", Annals of Internal Medicine, Sept. 17, 2002, p. 511.
[40] "Why competition law matters to health care quality", Health Affairs, Vol. 22, no. 2 (March/April 2003), p. 31.

planning should let the quality of services and beneficial outcomes define the level of competition, not the present failed system of CON review.

CON essentially serves as an ineffective means for rationing healthcare access to facilities, equipment (often innovation and technology) and services, thereby acting to ration care. Expanded access to healthcare and innovative new technologies has transformed modern lifestyles, improved the quality of life and life expectancy in the U.S., and contributed to increased productivity in the U.S. workforce. A CON regulatory system that has demonstrated that it cannot control costs, even by irrationally rationing healthcare, has now, in desperation, turned to the "Quality and Safety" issues as the "refuge of a scoundrel."

9. Summary

CON, although began with the best intentions, has failed in its goals of reducing costs, improving access and quality of care, and preventing duplication of medical services.[41]

In my view, the Alaska House of Representatives Health Education and Social Services Committee has an opportunity on behalf of the citizens of the State of Alaska to thoroughly investigate and eliminate a clearly failed health planning policy, which has undoubtedly cost the taxpayers of Alaska more than had CON never existed and impeded healthcare access for Alaska patients and their families. The Federal government, who first imposed CON on all the states, learned this early on after the change from a "cost plus" to a "prospective payment system" and has repeatedly denounced this failed health planning policy. CON has not achieved its stated purpose of reducing overall healthcare costs, as demonstrated by the preponderance of empirical evidence. Further, CON has caused severe regulatory interference in the healthcare market economy of Alaska in an uninformed, irrational, unfair and capricious manner.

I close by making a request of this committee and a commitment. The request is to urgently ask you to advance the efforts to repeal CON in Alaska. I commit to you that I will make available to you whatever related performance data, information and research related to the history of CON and its implementation in the State of Alaska as you may request. I urge you to get informed on this issue and offer to make myself and my staff available to any of you that may wish additional information in support of my position. I remain confident that once you have the facts, CON regulation in Alaska will be repealed.

Respectfully Submitted,

[41] *See* Aaron S. King, *Medical Market Failure in Maine: Is the Dirigo Reform Act's Certificate of Need a Market Correction?*, 22 Me. B.J. 156 (2007).

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EXPERIENCE

Robert James Cimasi, MHA, ASA, CBA, AVA, CM&AA, CMP is President of HEALTH CAPITAL CONSULTANTS (HCC), a nationally recognized healthcare financial and economic consulting firm. With over twenty years (20) of experience in serving clients, in over forty five (45) states, his professional focus is on the financial and economic aspects of healthcare service sector entities including: valuation consulting; litigation support & expert testimony; business intermediary and capital formation services; certificate-of-need and other regulatory and policy planning consulting; and, healthcare industry transactions including joint ventures, sales, mergers, acquisitions, and divestitures.

Mr. Cimasi holds a Masters in Health Administration from the University of Maryland, the Accredited Senior Appraiser (ASA) designation in Business Valuation, as well as, the Certified Business Appraiser (CBA), Accredited Valuation Analyst (AVA), the Certified Merger & Acquisition Advisors (CM&AA), and the Certified Medical Planner (CMP) professional designations (see *Professional Designations* section below). He is a nationally known speaker on healthcare industry topics, who has served as conference faculty or presenter for such organizations as the American Society of Appraisers (ASA), the Institute of Business Appraisers (IBA), the American Institute of Certified Public Accountants (AICPA), the National Association of Certified Valuation Analysts (NACVA), the American College of Healthcare Executives (ACHE), the National Society of Certified Healthcare Business Consultants(NSCHBC), the Academy Health, Healthcare Financial Management Association (HFMA), the American Association of Ambulatory Surgery Centers (AAASC),Physician Hospitals of America (PHA) f/k/a American Surgical Hospital Association (ASHA), National Litigation Support Services Association (NLSSA), as well as many other national and state healthcare industry associations and professional societies, trade groups, companies and organizations. He has been certified and has served as an expert witness on cases in numerous states, and has provided testimony before federal and state legislative committees. In 2006, Mr. Cimasi was honored with the prestigious *Shannon Pratt Award in Business Valuation* conferred by the Institute of Business Appraisers and was recently elevated to its College of Fellows in 2007. Mr. Cimasi is the author of *A Guide To Consulting Services for Emerging Healthcare Organizations* (John Wiley & Sons, 1999), *The Valuation of Healthcare Entities in a Changing Regulatory and Reimbursement Environment* (IBA Course 1011 text - 1999), and the author of *An Exciting Insight Into the Health Care Industry and Medical Practice Valuation* (AICPA course text 1997, rev. 2006.) He has authored chapters on healthcare valuation in The Handbook of Business Valuation (John Wiley & Sons), *Valuing Professional Practices and Licenses: A Guide for the Matrimonial Practitioner, 3rd ed., 1999* (Aspen Law & Business), and *Valuing Specific Assets in Divorce* (Aspen Law & Business) and has been a contributor to The Guide to Business Valuations (Practitioners Publishing Company). *Physician's Managed Care Success Manual: Strategic Options, Alliances, and Contracting Issues* (Mosby), and numerous other chapters. He has written published articles in peer review journals, frequently presented research papers and case studies before national conferences, and is often quoted by healthcare industry professional publications and the general media. Mr. Cimasi's latest book, *The U.S. Healthcare Certificate of Need Sourcebook*, was published in 2005 by Beard Books.

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- **AAASC**—American Association Ambulatory Surgery Centers
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- **ABA**—American Bar Association
- **ACHE**—American College of Healthcare Executives
- **ACM**—Association of Computing Machinery
- **AH**—Academy Health f/k/a Academy for Health Services Research and Health Policy
- **AHLA**—American Health Lawyers Association
- **AHPA**—American Health Planning Association
- **AM&AA**—The Alliance of Mergers and Acquisition Advisors
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- **NAFE**—National Association of Forensic Economists
- **NSCHIBC**—National Society of Certified Healthcare Business Consultants, F/k/a National Association of Healthcare Consultants (NAHC)
- **NBVG**—National Business Valuation Group
- **SHSMD**-Society for Healthcare Strategy and Market Development
- **SLBVR**—St. Louis Business Valuation Roundtable (Co-founder)
- **SLSAE**—St. Louis Society of Association Executives
- **TMA**—Turnaround Management Association

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- *"Testimony on H.B. 4: Medical Facility Certificate of Need"* Alaska House of Representatives Health Education and Social Services Committee, Juneau, AK (April 24, 2007).
- *"Testimony on H.B. 466"* Missouri House of Representatives Special Committee on Healthcare Facilities, Jefferson City, MO (February 6, 2007).
- *"Testimony on Certificate of Need"* Missouri Senate Interim Committee on Certificate of Need, Jefferson City, MO, (August 1, 2006).
- *"Testimony on Proposed Bill (H.B. 1537)"* Certificate of Need (CON) –Special Committee on Healthcare Facilities, Jefferson City, MO, (February 15, 2006).
- *"Testimony on Proposed Bill (H.B. 271)"* Hospital Ownership of Health Plans - House Health Care Policy Committee, Jefferson City, MO, (March 30, 2005).

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- *"Testimony on Proposed Bill (H.B. 585)"* Certificate of Need (CON) - House Health Care Policy Committee, Jefferson City, MO, (March 30, 2005).
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- *"Research for Valuations The Theory and Practice of Industry Data Gathering,"* Consultants' Training Institute Online Learning Lecture Series, National Association of Certified Valuation Analysts, (November 29, 2007).
- *"Valuation of Healthcare Ancillary Services Providers,"* Consultants' Training Institute, National Association of Certified Valuation Analysts, Philadelphia, PA (November 2, 2007).
- *"Valuation of Managed Care Organizations,"* Consultants' Training Institute Online Learning Lecture Series, National Association of Certified Valuation Analysts, (October 18, 2007).
- *"Valuation of Healthcare Ancillary Services Providers,"* Consultants' Training Institute, National Association of Certified Valuation Analysts, Phoenix, AZ (September 13, 2007).
- *"Aspects of Fraud Unique to Healthcare Valuation,"* Consultants' Training Institute's Online Learning Lecture Series, National Association of Certified Valuation Analysts, (August 9, 2007).
- *"Valuation of Ambulatory Surgery Centers,"* Eide Bailly, LLP Business Valuation Seminar. Minneapolis, MN (May 24, 2007.)
- *"Obtaining Certificates of Need For Outpatient Providers: Strategies for ASCs, Specialty Hospitals, Diagnostic Imaging, Cancer Treatment Centers, and Other Healthcare Facilities,"* Beard Audio Conferences, The Beard Group Law and Business Publishers (May 9, 2007).
- *"Valuation of Healthcare Ancillary Services Enterprises: Ambulatory Surgery Centers, Specialty Hospitals, Diagnostic Imaging Centers, Outpatient Cancer Treatment Centers, and Dialysis Facilities,"* Consultants' Training Institute's Online Learning Lecture Series, National Association of Certified Valuation Analysts, (May 3, 2007).
- *"IF WISHES WERE HORSES...' The Use of Empirical Data to Support Healthcare Valuations,"* The Institute of Business Appraisers 2006 Business Valuation Symposium, Clayton, MO (June 23, 2006).
- *"Valuation of Medical Practices in a Changing Regulatory and Reimbursement Environment,"* The Institute of Business Appraisers – Educational Course #1011. Clayton, MO (August 16, 2005).
- *"An Exciting Insight Into the Health Care Industry & Medical Practice Valuation,"* AICPA Course (#HCIV), sponsored by the Ohio Society of CPAs. Hudson, OH (September 13, 2002).
- *"Managed Care: Complete Guide to Mastering the Critical Health Care Issues,"* AICPA Course (#MCI), sponsored by the Indiana CPA Society. Indianapolis, IN (September 9, 2002).
- *"Health Care Consulting: New Practice Opportunities,"* AICPA Course (#HCC), sponsored by the Indiana CPA Society. Indianapolis, IN (October 8, 2001).
- *"The Valuation of Healthcare Entities in a Changing Regulatory and Reimbursement Environment,"* The Institute of Business Appraisers—Educational Course #1011. St. Louis, MO (September 10, 2001).
- *"Health Care Industry & Medical Practice Valuation,"* AICPA Advanced Business Valuation Course BVA-HC, sponsored by the Virginia Society of CPAs. Centerville, VA (September 25, 2000).

PROFESSIONAL COURSES TAUGHT (CONTINUED)

- *"The Valuation of Healthcare Entities in a Changing Regulatory and Reimbursement Environment,"* The Institute of Business Appraisers—Educational Course #1011. Indianapolis, IN (July 17, 2000).
- *"Health Care Industry & Medical Practice Valuation,"* AICPA Advanced Business Valuation Course BVA-HC, sponsored by Texas Society of CPAs. Dallas, TX (July 12, 2000).
- *"The Valuation of Healthcare Entities in a Changing Regulatory and Reimbursement Environment,"* Institute of Business Appraisers—Educational Course #1011. Cincinnati, OH (November 15, 1999).
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- *"Health Care Industry & Medical Practice Valuation,"* sponsored by Missouri Society of CPAs. St. Louis, MO (September 30, 1997).
- *"Health Care Industry & Medical Practice Valuation,"* sponsored by Georgia Society of CPAs. Atlanta, GA (September 29, 1997).
- *"Health Care Industry & Medical Practice Valuation,"* sponsored by Tennessee Society of CPAs. Brentwood, TN (September 15, 1997).
- *"Practice Abuse Seminar,"* Erie County Medical Society. Buffalo, NY (September 29, 1993)

ACADEMIC TEACHING ASSIGNMENTS

- *"Financial Benchmarking: Research and Application to the Healthcare Industry,"* Guest Instructor-Health Administration Program, Washington University School of Medicine, St. Louis, MO, Master of Health Administration (MHA) Program, Stuart Boxerman, D.Sc., Program Director. (January 27, 2005).
- *"The Surgical Hospital: Threat or Non-Threat to the Local Hospital,"* Guest Instructor-Health Administration Program, Washington University School of Medicine, St. Louis, MO, Master of Health Administration (MHA) Program, Stuart Boxerman, D.Sc., Program Director. (February 5, 2004).
- *"Practice Valuation: Issues for New Optometry Graduates,"* Practice Management IV Seminar, sponsored by University of Missouri—St. Louis, St. Louis, MO (October 21, 1998).
- *"Practice Valuation: Issues for New Optometry Graduates,"* Practice Management IV Seminar, Sponsored by University of Missouri - St. Louis, St. Louis, MO (October 23, 1997).
- *"Valuation of Health Care Professional Practices in a Changing Reimbursement & Regulatory Environment,"* Guest Instructor-Health Care Finance course (HA-667), Washington University School of Medicine St. Louis, MO, Master of Health Administration (MHA) Program, Robert S. Woodward, PhD, professor. (April 15, 1996).
- *"Valuation of Health Care Professional Practices in a Changing Reimbursement & Regulatory Environment,"* Guest Instructor-Health Care Finance course (HA-667), Washington University School of Medicine St. Louis, MO, Master of Health Administration (MHA) Program, Robert S. Woodward, PhD, professor. (April 5, 1995).
- *"Practice Abuse: Avoiding the Pitfalls of Private Practice,"* Medical Society of the County of Erie & Citibank, Buffalo, NY (September 29, 1993).
- *"Practice Management & Marketing Review,"* St. Vincent's Medical Center, Staten Island, NY (June 5, 1993).
- *"Negotiating Associateship Arrangements, & Practice Buy-ins,"* Winthrop University Hospital Mineola, NY (February 2, 1993).
- *"Practice Choice,"* Medical Society of the State of New York (MSSNY) State University of New York, Health Science Center at Syracuse, University Hospital. (March 11, 1992).
- *"Practice Management & Marketing Review,"* State University of New York Health Science Center at Syracuse University Hospital, Syracuse, NY (November 18, 1992).

LECTURES AND PRESENTATIONS

- "Developing and Implementing a Successful Certificate of Need Strategy, GE Healthcare Second Annual Outpatient Imaging Center Conference, Washington D.C., July 26, 2007.
- "Benefits of Physician Ownership of Ambulatory Surgery Centers," American Association of Ambulatory Surgery Centers Annual Meeting 2007, Denver Colorado, May 18, 2007.

LECTURES AND PRESENTATIONS (CONTINUED)

- "The Four Pillars" Supporting the Future of Healthcare: A Look at Market Forces," Missouri League for Nursing 2007 Annual Convention, Tan-Tar-A, MO, April 13, 2007.
- "Quantifying Business Interruption Damages," National Association of Certified Valuation Analysts Missouri State Chapter Meeting 2007, St. Louis, MO, January, 26, 2007.
- *"The Orthopedic Single Specialty Hospital: Is it Still Possible."* Winning Off the Field: The AOSSM Practice Management Workshop, The American Orthopedic Society of Sports Medicine, Phoenix, AZ, December 1, 2006.
- *"The Attack on Orthopedic Providers at Federal and State Levels and How to Defend Yourself."* Winning Off the Field: The AOSSM Practice Management Workshop, The American Orthopedic Society of Sports Medicine, Phoenix, AZ, December 1, 2006.
- *"Successful Advocacy,"* Panel Member, American Association of Ambulatory Surgery Centers State Leadership Retreat, Scottsdale, AZ, October 28, 2006.
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ASHNHA Comments on CS for House Bill 337 (HES Version 'N')
Prepared by: Rod Betit, President/CEO • April 4, 2008

I. Sectional Overview:	Recommendation
▪ Section 1 - Legislative Findings & Intent	SUPPORT
▪ Section 2 - Statewide Health Plan	SUPPORT
▪ Section 3- Re-define "expenditure"	OPPOSE
▪ Section 4 - Define "health care facility" & Repeal CON	OPPOSE
▪ Section 5 - Add new definitions	AMEND
▪ Section 6 - Health Care Information Office & Reporting	AMEND
▪ Section 7 - Establish Commission	AMEND
▪ Section 8 - CON Repeal Transition Steps	OPPOSE
▪ Section 10 - CON Study	SUPPORT
▪ Section 11 - Effective Date for Section 9	OPPOSE
▪ Section 12 - Mandatory Reporting Effective Date	SUPPORT

II. Sectional Analysis:

Section 1 - Findings & Intent: SUPPORT

ASHNHA members agree with the policy statement expressed in this Section.

Section 2 - Statewide Health Plan SUPPORT

ASHNHA members support the creation and regular updating of a statewide health plan.

Section 3 - Re-define Expenditure OPPOSE

This is a new section modifying the definition currently being used to determine which projects exceed the dollar threshold that would trigger a CON review. This new language is unclear to ASHNHA members as to how it would improve or clarify projects under review by the department. In addition this new language only includes equipment when computing project costs. Current law includes both equipment and property related costs. Current language is recommended over this new proposed language.

Section 4 - Define "Health Care Facility" & Partial Repeal of CON: OPPOSE

This Section would repeal CON in municipalities or boroughs with populations over 60,000 persons not including recipients of public health care who are military or Indian Health Service covered. The effect of this language would be to effectively repeal CON in Mat-Su, Anchorage and Fairbanks. Repeal of CON would be detrimental to Alaska consumers, not helpful.

HB337 is being pitched as a way to increase competition and decrease costs, but it would have the exact opposite effect. As stated recently in a St Louis editorial, the fact that repeal of CON does not increase competition and lower costs is often *"counter-intuitive."*

The editorial goes on to note that *"Wisconsin and Ohio both did away with their CON requirements. But the promised savings failed to materialize. What came instead was.*

- *26 new hospitals were built when Ohio's CON law was repealed.*
- *82 new multi-million dollar MRI and CT scan centers were opened.*

- *The number of open heart surgeries performed in the state jumped by 38 percent. Many were judgment calls, done at the discretion of doctors who otherwise would opt for a more conservative approach than surgery.*
- *When Pennsylvania's CON law was repealed, the number of MRI machines jumped from 78 to 187 and capacity at cardiac catheterization labs jumped by 90 percent.*

"All that new equipment and expertise has to be paid for somehow. A 2001 study by Chrysler, Ford and General Motors shows the effect. The study examined health costs over several years in eight states, including Missouri. It found that costs were 11 to 39 percent lower in states with CON requirements than in those without it.

"In a landmark study, Dartmouth University researchers found that Medicare pays twice as much per patient in Miami as it does in Minneapolis. The difference largely is because Florida patients are more likely to be referred to medical specialists, where they often are given expensive tests and admitted to hospitals.

"But the patients in Miami don't live longer or have a better quality of life than those in Minneapolis. A more recent Dartmouth study found that patients in cities where health spending was highest actually died sooner than those where it was lower."

Alaska would be taking a huge risk by enacting any repeal of CON absent empirical data that increased competition and lower costs would actually come about. That data does not exist at the present time. The most likely impact of repealing CON would be to further erode community hospitals financial ability to provide needed medical services to everyone, including those who cannot pay.

The amount of Bad Debt that hit Alaska's hospitals increased by 55% between 2006 and 2007. Nationally during this same period Bad Debt increased 14.1%. Repeal of CON would reduce hospitals revenue from more profitable service areas that are used to offset part of this growing Bad Debt problem, and to fund the 24/7 areas of medical care like Emergency Departments.

<u>Section 5 - Add New Definitions:</u> AMEND

Some of the proposed definitions are helpful (#11, 12, 14, 15, & 16) while two are not, #13 dealing with IDTFs versus a practice with imaging equipment and #17 which attempts to define a 'physician office'.

Definition #13 should be replaced with language from HB 345 that clarifies when imaging equipment purchased for a physician's office is exempt from CON review. Adding this language in place of definition #13 would also eliminate 80% of the lawsuits and appeals currently before the State on imaging CON decisions that the Department of Health & Social Services has made in the last two years.

Definition #17 should be deleted in its entirety as there is no useful purpose for attempting to define what is or is not a physician office. Physician offices have always been exempt from CON in Alaska and this proposed definition would simply create interpretive complexity to an area that is already very clear.

Section 6 - Health Care Information Office & Mandatory Reporting AMEND

ASHNHA members strongly support efforts to provide consumers with better information to guide their health care purchases but there are several amendments which are important to make to this Section. Specifically:

- Replace language on lines 12 & 13, page 5 with new language that reads "(1) information about health care services, price, and quality to aid consumers in making health care decisions; and"
- Add language on line 22, page 5, after the word 'information' "with the health care facility".
- Add after 'and' on line 1, page 7, a new #11 that reads "(11) a list of physicians who accept patients with Medicare coverage;" Renumber accordingly.
- Replace language on lines 12 - 14, page 7 with new language that reads "(1) information on costs to and bills payable by the consumer for health care services that include both facility and physician components of care.
- Add new E and F after line 27, page 8 that add requirement for pharmacies and physicians to report. It is critical that pharmacy and physician information be part of the data base that consumers have access to in making health care decisions. New language to add:
  - "(E) a licensed pharmacy; and
  - "(F) a physician's office.

Section 7 - Establish Health Care Commission: AMEND

ASHNHA strongly supports creation of a Health Care Commission. While there are several different membership structures being proposed in different legislation, it is important that a Commission of some structure is created.

It is important to note also that in this HES version of HB 337, the responsibilities of the Commission have been diluted to simply review and advise the Department on health care information reporting rather than "approving" the process (see line 9 on page 11). ASHNHA strongly recommends amending this section to give the Commission authority to define the reporting requirements for each health care category. The Commission is the more appropriate body for determining what is most useful to consumers in weighing health care decisions that must be made.

Section 8 - CON Repeal Transition Steps: OPPOSE

ASHNHA's members do not support any repeal of CON and therefore believe this section should be deleted.

Section 9 - CON Transition Regulations: OPPOSE

ASHNHA's members do not support any repeal of CON and therefore believe this section should be deleted.

Section 10 - CON Study: SUPPORT

ASHNHA strongly supports completion of an Alaska specific CON Study to address the question of what impact CON repeal would have in Alaska. Future debate of this topic would be enhanced by identification of any data unique to Alaska that might shed light on any positive or negative impacts that the Alaska CON process has had on consumer access and cost for health care services.

Section 11 - Effective Date for Section 9: OPPOSE

ASHNHA's members do not support any repeal of CON and therefore believe this section should be deleted.

Section 12 - Mandatory Reporting Date: AMEND

This HES version of HB 337 continues to have a July 1, 2008 effective date for reporting information. Even with a staggered implementation of this provision for different health care provider types, it is unrealistic to expect that the Department can actually begin receiving and posting reported information prior to July 1, 2009.

Thank you for the opportunity to testify and express ASHNHA's members' opinions about this legislation.

Competition in Healthcare and Certificates of Need

JOSEPH M. MILLER
Assistant Chief, Litigation I Section
U.S. Department of Justice, Antitrust Division

January 31, 2008[1]

Good afternoon. I appreciate the invitation to the Antitrust Division of the U.S. Department of Justice to share our views on the impact of Certificate of Need ("CON") laws on healthcare markets.

My name is Joseph Miller. I am the Assistant Chief of the Litigation I Section of the Antitrust Division. The Litigation I Section enforces the antitrust laws in a wide variety of industries, including healthcare markets. Our attorneys confer closely with a large team of economists holding doctorates in the study of markets and their performance, including a number with specialization in the performance of healthcare markets. We also confer closely with the attorneys and economists at the Federal Trade Commission, who have dedicated time to the study of healthcare markets.

The Antitrust Division and the FTC have investigated and litigated antitrust cases in markets across the country involving hospitals, physicians, ambulatory surgery centers, stand-alone radiology programs, medical equipment, pharmaceuticals and other healthcare products. Through that work we have developed a substantial understanding of the competitive forces that drive innovation in and contain the costs of healthcare. We regularly issue informal advisory letters on the application of the antitrust laws to healthcare markets, and periodically issue reports and general guidance to the healthcare community. For example, in 2003, we conducted 27 days of hearings on competition and policy concerns in the healthcare industry, heard from approximately 250 panelists, elicited 62 written submissions, and generated almost 6,000 pages of transcripts.[2] As a result of that effort, we published an extensive report, entitled *Improving Health Care: A Dose of Competition*, in July 2004.

I. Scope of Remarks

The Antitrust Division's experience and expertise has taught us that Certificate of Need laws pose a substantial threat to the efficient performance of healthcare markets. By their very nature, CON laws create barriers to entry and expansion and thus restrict free and open

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[1] This paper draws significantly from testimony delivered on behalf of the Antitrust Division to the General Assembly and Senate of the State of Georgia on February 23, 2007.

[2] This extensive hearing record is largely available at http://www.ftc.gov/bc/healthcare/research/healthcarehearing.htm.

competition. They undercut consumer choice, weaken markets' ability to contain healthcare costs, and stifle innovation.

We have examined historical and current arguments for CON laws, and conclude that such arguments provide no economic justification for depriving consumers' of the benefits of free markets. To the extent that CONs are used to further non-economic goals, they impose substantial costs. Such goals, purportedly furthered through CON laws, can be more efficiently achieved through other mechanisms. We hope you will carefully consider the substantial costs that CON laws impose on consumers as you evaluate whether to eliminate those laws in Alaska.

I do not testify today to discuss the details of the legislation you are considering. I am, however, generally familiar with the issues before you and recognize them as issues that CON laws present in other states and other markets. My remarks, accordingly, will focus on the impact of and justifications for CON laws generally.

It is not the Antitrust Division's intent to "favor any particular procompetitive organization or structure of health care delivery over other forms that consumers may desire. Rather, [our] goal is to ensure a competitive marketplace in which consumers will have the benefit of high quality, cost-effective health care and a wide range of choices . . ."[3] Our overall mission is to preserve and promote economic competition rather than to preserve any particular marketplace rival or group of rivals.

II. Importance of Competition and the Harm Caused by Regulatory Barriers to Entry

A. The Benefits of Competition in Healthcare

Our concerns about the harm from CON laws are informed by one fundamental principle: market forces improve the quality and lower the costs of healthcare services. They drive innovation and ultimately lead to the delivery of better healthcare. Government intervention can undermine market forces to the detriment of healthcare consumers.

In our antitrust investigations we often hear the argument that healthcare is "different" and therefore competition principles do not apply to the provision of healthcare services. The proposition that competition cannot work in healthcare is simply not true. Engineers and lawyers have made similar arguments that competition does not work in their industries and, in fact undermined other social goods advanced by their professions. Such arguments have been rejected by the courts, and private restraints on competition have long been condemned.[4] Indeed, at least since the Supreme Court's seminal 1943 decision in a case brought by the Department of Justice against the American Medical Association, competition has played a critical role in

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[3] Statements of Antitrust Enforcement Policy in Health Care, August 1996, Introduction, pg. 3 (available at: http://www.usdoj.gov/atr/public/guidelines/1791.htm).

[4] *F.T.C. v. Superior Court Trial Lawyers Ass'n*, 493 U.S. 411 (1990); *National Society of Professional Engineers v. U.S.*, 435 U.S. 679 (1978).

shaping the delivery of healthcare in this country.[5] The Antitrust Division and the Federal Trade Commission have worked diligently to make sure that private barriers to that competition do not arise.

During our extensive healthcare hearings in 2003, we obtained substantial evidence generally about the role of competition in our healthcare delivery system and reached the conclusion that vigorous competition among healthcare providers "promotes the delivery of high-quality, cost-effective healthcare." Specifically, competition results in lower prices and broader access to health care and health insurance, while non-price competition can promote higher quality.[6]

This finding is not new. We saw in the 1990s the growth of managed care and the impact it had on the cost and availability of insurance. Competition among and between hospitals and physicians intensified with the development of managed care organizations. In addition to putting pressure on costs, managed care plans have pressured providers to use shorter hospital stays and to offer alternative outpatient treatments. This evolution in health care purchasing led to lower costs and increased choice without sacrificing quality. Moreover, lower costs and improved efficiency made health insurance more affordable and available.

Competition also helped bring to consumers important innovations in healthcare technology. For example, health plan demand for lower costs and "patient demand for a non-institutional, friendly, convenient setting for their surgical care" drove the growth of Ambulatory Surgery Centers (ASCs).[7] Ambulatory surgery centers offered patients more "convenient locations, shorter wait time, and lower coinsurance than a hospital department."[8] Important to the success of these competitive forces in improving the delivery of care to consumers was the availability of technological advances, such as endoscopic surgery and advanced anesthetic agents.[9] Thus, competition harnessed this new technology and brought it to consumers in the lower cost, more convenient setting of ambulatory surgery centers. The impact on traditional general acute care hospitals led to those hospitals responding to the competition by delivering more care, in a better manner, in an outpatient setting, both at their own campuses and at ambulatory surgery centers in which they invested.

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[5] *American Medical Association v. U.S.*, 317 U.S. 519, 529 (1943).

[6] *Improving Health Care: A Dose of Competition*, ch. 3 § VIII and Executive Summary at 4 (July 2004) available at http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf. ("*A Dose of Competition*").

[7] Id., Ch. 3 at 25.

[8] Medicare Payment Advisory Commitions (MedPAC), Report to the Congress: Medicare Payment Policy § 2F, at 140 (2003), available at http://www.medpac.gov/publications/congressional_reports/Mar03_Entire_report.pdf.

[9] A Dose of Competition, at ch. 3 at 24.

This type of competitive success story has occurred again and again in healthcare in the area of pharmaceuticals, urgent care centers, and elective surgeries such as Lasik procedures, to name just a few. Without private or governmental impediments to their performance, we can expect healthcare markets to continue to deliver these benefits.

B. CON Laws Create Barriers to Beneficial Competition

CON laws are a classic government-erected barrier to entry, and by their nature are an impediment to the proper functioning of the market process. Accordingly, in *A Dose of Competition*, the Federal Trade Commission and we urged the states to rethink their CON laws.[10]

1. Original Cost-Control Reasons For CON Laws No Longer Apply

We made that recommendation in part because the original reason for the adoption of CON laws is no longer valid. Many CON programs trace their origin to a repealed federal mandate, the National Health Planning and Resources Development Act of 1974, which offered incentives for states to implement CON programs. At the time, the federal government and private insurance reimbursed healthcare charges predominantly on a 'cost-plus" basis, which provided incentives for over-investment. The hope was that CON laws would provide a counterweight against that skewed incentive.

In considering this historical justification for CON laws, we need to keep clear that a number of other arguments made today in support of CON laws were not part of the rationale for their original adoption –

* CON laws were not adopted as a means of cross-subsidizing care;
* CON laws were not adopted in order to have centralized planning of the location and nature of healthcare facilities; and,
* CON laws were not adopted to protect the health and safety of the population from poor quality medicine.

Instead, CON laws were adopted because excessive capital investments, spurred by the then-current cost-plus method of reimbursement, were driving up healthcare costs. There was concern that, because patients are usually not price-sensitive, providers engaged in a "medical arms race" by unnecessarily expanding their services to offer the perceived highest quality services.[11]

CON laws appear to have failed in their intended purpose of containing costs. Several studies have examined the effectiveness of CONs in controlling costs. The empirical evidence

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[10] *A Dose of Competition*, Executive Summary at 22.

[11] *A Dose of Competition*, Ch. 8, pg. 1-2.

on the economic effects of CON programs has demonstrated near-universal agreement among health economists that CON laws were unsuccessful in containing healthcare costs.[12]

In addition to the fact that CON laws have been ineffective in serving their original purpose, CON laws should be reexamined because the reimbursement methodologies that may in theory have justified them initially have changed significantly since the 1970s. The federal government no longer reimburses on a cost-plus basis. In 1986, Congress repealed the National Health Planning and Resources Development Act of 1974. Additionally, health plans and other purchasers routinely bargain with healthcare providers over prices. Essentially, government regulations have changed in a way that eliminates the original justification for CON programs.[13]

2. Protecting Revenues of Incumbents Does Not Justify CON Laws

Incumbent hospitals often argue that they should be protected against additional competition so that they can continue to cross-subsidize care provided to uninsured or under-insured patients. Under this rationale, CON laws would impede the entry of such healthcare providers as independent ambulatory surgery centers, free-standing radiology or radiation-therapy providers, single- or multi-specialty physician-owned hospitals, because if these new competitors were to enter the marketplace, community hospitals could not continue to exploit their existing market power over consumers. Put another way, without CON laws, we would see new, higher-quality, low cost providers in the marketplace, which would put competitive pressure on incumbent providers, and deprive them of revenues they could put to a charitable use.[14]

We fully appreciate the laudatory goal of providing sufficient funding for community hospitals so that these hospitals can provide health care services to those who cannot afford them and for whom government payments are either unavailable or too little to cover the cost of care. But, we also want to make clear that the use of government barriers to entry to fund indigent care has costs. There are more efficient ways to accomplish this goal without incurring the costs of impeding the proper functioning of health care markets. Essentially, by protecting incumbent hospitals from competition, CON laws allow dominant hospitals to tax consumers through the exercise of market power in order to pursue the charitable goal of providing care to other, less fortunate consumers. In using this funding mechanism, however, the CON laws may do more harm than good.

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[12] David S. Salkever, Regulation of Prices and Investment in Hospital in the United States, in 1B Handbook of Health Economics, 1489-590 (A.J. Culyer & J.P. Newhouse eds., 2000) ("there is little evidence that [1970's era] investment controls reduced the rate of cost growth.")

[13] *A Dose of Competition* at pg. 1-6.

[14] Note the irony of this argument. What started as laws intended to control costs have become laws intended to inflate costs. Proponents of CON laws now would use these barriers to entry to stifle competition, protect incumbent market power, frustrate consumer choice, and keep prices and profits high.

First, CON laws harm the consumers who would have chosen alternative, lower priced, higher quality, or more convenient sources of care.

Second, CON laws impose that cost without any clear evidence that other desired social goals are advanced. The evidence to date indicates that new competition does not undercut community hospitals' ability to fulfill charitable missions. Recently the federal government studied just this issue in connection with the emergence of single-specialty hospitals around the country. The study found that, for several reasons, specialty hospitals did not undercut the financial viability of rival community hospitals.[15] One substantial reason for this was that specialty hospitals generally locate in areas that have above average population growth. Thus, they are competing for a new and growing patient population, not just siphoning off the existing customer base of the community hospitals.

Third, new competition can force community hospitals to improve their performance. In studying the effect of single-specialty hospitals, MedPAC found that the community hospitals responded to the competition by improving efficiency, adjusting their pricing, and expanding profitable lines of business.[16] Community hospitals encouraged physicians to perform procedures on the hospital campus by developing centers of excellence and building physician offices on campus.[17] Overall, community hospitals affected by specialty hospital entry maintained profit margins in line with national averages. Rather than undercutting community hospitals, new entry drives them to do a better job. Thus, in addition to the harm to the consumers who would have chosen the new healthcare provider, CON laws harm society in general by depriving it of the increased efficiency that competition would have brought to the health care market.

3. CON Laws Impose Other Costs And May Facilitate Anti-Competitive Behavior

CON laws appear to raise a particularly substantial barrier to entry and expansion of competitors because they create an opportunity for existing competitors to exploit procedural

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[15] Report to the Congress: Physician-Owned Specialty Hospitals Revisited, pg. 21-25 (August 2006), available at http://www.medpac.gov/publications/congressional_reports/Aug06_specialtyhospital_mandated_report.pdf. ("MedPAC 2006 Report") (concluding that physician-owned specialty hospitals admit a lower proportion of Medicaid patients)

[16] Other studies have found that the presence of for-profit competitors leads to increased efficiency at nonprofit hospitals. Kessler, D. and McClellan M., "The Effects of Hospital Ownership on Medical Productivity," RAND Journal of Economics 33 (3), 488-506 (2002).

[17] Greenwald, L. et al., "Specialty Versus Community Hospitals: Referrals, Quality, and Community Benefits," *Health Affairs* 25, no. 1 (2006): 116-117. *See also* Stensland J. and Winter A., "Do Physician-Owned Cardiac Hospitals Increase Utilization?" *Health Affairs* 25, no. 1 (2006): 128 (some community hospitals have responded to the presence of specialty hospitals by recruiting physicians and adding new cardiac catheterization labs).

opportunities to thwart or delay new competition. Such behavior, commonly called "rent seeking" conduct, is a well-recognized consequence of regulatory intervention in the market.[18] Essentially, an existing competitor uses the hearing and appeals process to cause substantial delays, leading both the existing competitor and the new entrant to divert significant funds away from delivering healthcare and to spend them on legal fees, consulting fees, and lobbying efforts. Moreover, much of this conduct, even if exclusionary and anticompetitive, is unlikely to be subject to legal challenge as a violation of the antitrust laws because it involves petitioning of the state government by the existing competitor.[19] Indeed, during our hearings, we received evidence of the widespread recognition that existing competitors use the CON process "to forestall competitors from entering an incumbent's market."[20]

We have found that existing competitors, at times with the encouragement or acquiescence of state officials, go further and enter into agreements not required by the CON laws but nonetheless facilitated by them. Two examples arise from West Virginia, and a third comes from Vermont.

In the first West Virginia case, we found that a Charleston, West Virginia hospital used the threat of objection during the CON process, and the potential ensuing delay and cost, to induce a hospital seeking a certificate of need for an open heart surgery program not to apply for it at the location that would have well served Charleston consumers and provided greater competition for their business.[21] Instead, the Charleston hospital successfully prevented the possibility of this competing open heart program. The state authorities never had the opportunity to decide whether under the CON laws that second program would have been approved because of the unlawful agreement among the hospitals.

In the second West Virginia case, two closely competing hospitals decided to allocate healthcare services between themselves.[22] The informal urging of state CON officials led them to agree unlawfully that only the one hospital would apply for an open heart program and only the other would apply to provide cancer services. Again, the state took no official action and consumers were deprived of the potential competition between these hospitals.

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[18] Joskow, Paul and Rose, Nancy, "The Effects of Economic Regulation," *Handbook of Industrial Organization, vol. 2*, Schmalensee and Willig, ed. Amsterdam: North-Holland, 1989.

[19] *Eastern Rail. Pres. Conf. v. Noerr Motor Frgt., Inc.*, 365 U.S. 127 (1961).

[20] *A Dose of Competition*, Executive Summary at 22.

[21] *U.S. v. Charleston Area Medical Center, Inc.*, Civil Action 2:06 -0091 (S.D.W.Va. 2006) (available at: http://www.usdoj.gov/atr/cases/f214400/214477.htm).

[22] *U.S. v. Bluefield Regional Medical Center, Inc.*, 2005-2 Trade Cases ¶ 74,916 (S.D. W.Va. 2005).

A third example comes from the State of Vermont. There, home health agencies entered into territorial market allocations, again under cover of the state regulatory program, to give each other exclusive geographic markets.[23] That state's CON laws prevented competitive entry, which normally might have disciplined such cartel behavior. We found that Vermont consumers were paying higher prices than were consumers in states where home health agencies competed against each other.

We have learned from these matters and others that CON laws have the potential to impede competition in ways well beyond what is intended by their supporters.

III. Conclusion

My remarks are intended to convey to you our belief that CON laws impose substantial costs on consumers and healthcare markets. In light of these costs, the Antitrust Division believes that Alaska should carefully consider whether on balance its CON laws do more harm than good. Let me close by encouraging you not to accept without careful scrutiny claims that elimination of CON laws will visit significant harm on your state.

Thank you again for the opportunity to discuss our views on how CON laws affect competition and consumers in healthcare. I would be happy to take your questions.

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[23] Department of Justice Statement on the Closing of the Vermont Home Health Investigation, (Nov. 23, 2005) (available at: http://www.usdoj.gov/atr/public/press_releases/2005/213248.htm).

PREPARED STATEMENT OF
THE FEDERAL TRADE COMMISSION

Before the

STANDING COMMITTEE on HEALTH, EDUCATION & SOCIAL SERVICES

of the

ALASKA HOUSE OF REPRESENTATIVES

on

House Bill 337, "An Act establishing the Alaska Health Care Commission and the Alaska health care information office; relating to health care planning and information; relating to the certificate of need program for certain health care facilities; and providing for an effective date."

Who asked for this? DHSS
who paid for it? Moore
Where + how was it done? - Dan Gillman from F.T.C.

February 15, 2008

Did any members of the commission come to Alaska? No

I. Introduction

The Federal Trade Commission (FTC) is pleased to have the opportunity to discuss health care competition, Alaska's certificate of need (CON) laws, and Alaska House Bill 337 (H.B. 337), which would modify certain of Alaska's CON laws.[1] The Commission believes that CON laws such as Alaska's can be a barrier to entry to the detriment of health care competition and health care consumers, and that the legislature should consider their repeal. The Commission's conclusion is based on the joint FTC/Department of Justice (DOJ) report, *Improving Hea th Care: A Dose of Competition* (Report or FTC/DOJ Report),[2] its underlying research, and recent work by FTC staff and the staffs of our sister agencies, such as DOJ and the Centers for Medicare & Medicaid Services (CMS) of the Department of Health and Human Services. As noted in the FTC/DOJ Report, "[t]he Agencies believe that, on balance, CON programs are not successful in containing health care costs, and that they pose serious anticompetitive risks that usually outweigh their purported economic benefits."[3]

Congress has charged the Commission with preventing unfair methods of competition and unfair or deceptive acts or practices in or affecting commerce.[4] Pursuant to its statutory mandate, the FTC seeks to identify business practices and regulations that

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[1] The FTC initially was invited to submit testimony regarding H.B. 337, as introduced on January 22, 2008, which would have repealed Alaska's CON requirements generally; a more recent committee substitute draft also before the relevant Alaska house committee (but not yet available publicly) would repeal only certain of Alaska's CON requirements, but leave others – such as those regarding nursing homes – intact.

[2] FEDERAL TRADE COMMISSION & THE DEPARTMENT OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION (July, 2004) [hereinafter "IMPROVING HEALTH CARE"].

[3] *Id.* at Executive Summary, p. 22.

[4] Federal Trade Commission Act, 15 U.S.C. § 45.

impede competition without offering countervailing benefits to consumers. For several decades, the FTC and its staff have investigated the competitive effects of restrictions on the business practices of health care providers.[5] Included in that general body of health care competition work have been hearings, studies, and reports addressing issues raised by CON laws.

Specifically, the FTC/DOJ Report discusses critically the role of CON laws in health care competition, both as a distinct policy issue and as an important component of other health care competition issues, such as entry problems in hospital markets. The Report broadly examined the state of the health care marketplace and the role of competition, antitrust, and consumer protection in satisfying the preferences of Americans for high-quality, cost-effective health care. The Report was based, among other things, joint FTC/DOJ hearings that took place over 27 days from February through October 2003, following a Commission-sponsored workshop on health care issues in September 2002. The FTC and DOJ heard testimony from about 240 panelists, including representatives of various provider groups, insurers, employers, lawyers, patient advocates, and leading scholars on subjects ranging from antitrust and economics to health care quality and informed consent. Together, the hearings and workshop elicited written submissions from interested parties. Almost 6,000 pages of transcripts of the hearings and workshop and all written submissions are available on the Commission website, www.ftc.gov. In addition, FTC and DOJ staffs undertook independent research for the Report.

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[5] *See* Federal Trade Commission, *FTC Antitrust Actions in Health Care Services and Products* (Oct. 2003), *available at* http://www.ftc.gov/bc/healthcare/0310234.pdf.

In this testimony, the Commission focuses specifically on a few of the issues discussed in the Report that address CON laws and new entry into competition among health care facilities. Three main points require attention:

- First, vigorous competition among healthcare providers, such as hospitals, clinics, and nursing homes, usually benefits consumers through better and more varied services and, in some cases, lower prices. CON laws were designed to create barriers to entry for new healthcare facilities or providers to contain the costs of healthcare services. CON laws, however, have not been particularly effective in controlling healthcare costs, while posing significant risks to competition. In particular, CON laws can retard the entry of firms that could provide higher quality services or lower prices than those offered by incumbents, depress consumer choice between qualitatively different treatment options or settings, or reduce the pressure on incumbents to improve qualitative aspects of their own offerings. Policymakers would be wise to consider reviewing all of the actual costs, benefits, and consequences – intended and unintended – of a regulatory system when assessing that system's future.
- Second, the CON regulatory system creates both the incentive and means by which an incumbent healthcare provider can use the regulatory system itself to delay effective competition, independent of the demand for additional healthcare services. This additional loss of competition is a further regulatory cost that must be weighed in the balance when assessing the public interest.

- Finally, Alaska currently has one of the most stringent CON laws in the United States. House Bill 337's proposed amendment of this law would eliminate or reduce barriers to entry for a broad range of healthcare service providers, including small entities that might then be able to thrive as never before.

These points are addressed more fully, below.

II. Discussion

A. Provider Competition Generally: Competition has important benefits in health care services markets, just as it has in the multitude of markets in the U.S. economy that rely on competition to maximize the welfare of consumers. Competitive pressures can lead hospitals and other entities to lower costs, improve quality, and compete more efficiently. In particular, competitive pressure may spur new types of competition. In some hospital markets, new entrants specialize and provide only a limited portion of the in-patient and out-patient services that general hospitals tend to provide.[6] Elsewhere, health care services once delivered only in large hospitals – and requiring overnight stays – may be performed more conveniently and less invasively, at lower cost, in outpatient settings. In addition, both traditional providers and new entities have explored new means to expand access to basic health care by, for example,

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[6] *See generally Prepared Statement of the Federal Trade Commission, Before the S. Subcomm. On Federal Financial Management, Gov't Information and Int. Security of the S. Comm. on Homeland Security and Governmental Affairs, on New Entry Into Hospital Competition* (May 24, 2005) (regarding, e.g., new specialty hospital entry), *available at* http://www.ftc.gov/os/2005/05/05240snewentryintohospitalcomp.pdf; *see also* UNITED STATES DEPT. OF HEALTH AND HUMAN SERVICES, FINAL REPORT TO THE CONGRESS AND STRATEGIC IMPLEMENTING PLAN REQUIRED UNDER SECTION 5006 OF THE DEFICIT REDUCTION ACT OF 2005 (2006) [hereinafter "HHS FINAL REPORT"], *available at http://www.cms.hhs.gov/PhysicianSelfReferral/06a_DRA_Reports.asp*

establishing limited service clinics that can provide more convenient and lower cost care and bring more consumers into contact with the larger health care system.[7]

Although new strategies for lowering costs and enhancing quality are emerging, competition is not as effective as possible in most health care markets, because the prerequisites for competitive markets are not fully satisfied. Of particular concern for today's purpose is the extent to which state regulations can create barriers to entry in health care markets, without conferring countervailing benefits in quality of care or cost containment.[8]

At the same time, the empirical evidence generally does not indicate that CON laws control health care costs.[9] Recent broad studies analyzing both national and state

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[7] *See, e.g.*, FTC Staff Comment Before the Massachusetts Department of Public Health Concerning Proposed Regulation of Limited Service Clinics, 1-2 (Oct. 2007).

[8] In discussing competition concerns raised by CON requirements, the Commission does not mean to suggest that state CON regulations are the only regulatory impediments to competitive forces in health care markets. For example, in testimony before the House Committee on Energy and Commerce on May 12, 2005, Mark McClellan, then Administrator of CMS, reported that CMS, following its own study of specialty hospitals pursuant to congressional direction, would analyze and reform its payment rates "to help reduce the possibility that specialty hospitals may take advantage of imprecise payment rates in the inpatient hospital prospective payment system" and "to diminish the divergences in payment levels [for ambulatory surgical centers] that create artificial incentives for the creation of small orthopedic or surgical hospitals." *Testimony of Mark B. McClellan, M.D., Ph.D., Administrator, Centers for Medicare & Medicaid Services, Before the H. Comm. on Energy and Commerce Hearing, "Specialty Hospitals Assessing Their Role in the Delivery of Quality Health Care,"* (May 12, 2005), *available at* http://www.hhs.gov/asl/testify/t050512.html; *see also Testimony of Mark B. McClellan, M.D., Ph.D., Administrator, Centers for Medicare & Medicaid Services, on Physician-Owned Specialty Hospitals Before the S. Finance Comm.* (May 17, 2006), *available at http://www.hhs.gov/asl/testify/t060517b.html*

[9] IMPROVING HEALTH CARE, *supra* note 2, at C. 8, at pp. 1-6. Although the larger body of CON literature – including anecdotal reports and small, uncontrolled studies – presents somewhat mixed conclusions on cost savings, the conclusions of the FTC/DOJ Report and staff research have substantially been borne out by more recent, sophisticated large-scale data analyses and literature reviews. "[O]n balance, the most methodologically sound studies have found that CON has no effect or actually increases both hospital spending per capita and total spending per capita." CHRISTOPHER J. CONOVER & FRANK A. SLOAN, EVALUATION OF CERTIFICATE OF NEED IN MICHIGAN, CENTER FOR HEALTH POLICY, LAW AND MANAGEMENT, TERRY SANFORD INSTITUTE OF PUBLIC POLICY, DUKE UNIVERSITY, A REPORT TO THE MICHIGAN DEPT. OF COMMUNITY HEALTH, 30 (May 2003) (reviewing literature and discussing national and Michigan-specific material regarding acute care [hospitals, MRI services, cardiac services] CON laws) (hereinafter "CONOVER & SLOAN, REPORT TO MICHIGAN"); WASHINGTON STATE JOINT LEGISLATIVE AUDIT AND REVIEW COMMITTEE (JLARC), EFFECTS OF CERTIFICATE OF NEED AND ITS POSSIBLE REPEAL, 1 (Jan. 8, 1999) ("The study found that CON has not controlled overall health care spending or hospital costs

data reveal "little evidence that CON results in a reduction in costs and some evidence to suggest the opposite."[10] Studies also fail to show any consistent increase or surge in health care spending when states remove or modify their CON requirements.[11]

Barriers to entry can affect qualitative competition as well. As the Report noted, state CON laws can retard the entry of firms that could provide higher quality services than those offered by incumbents.[12] That may tend to depress consumer choice between qualitatively different treatment options or settings,[13] or it may reduce the pressure on incumbents to improve qualitative aspects of their own offerings

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The study generally found either conflicting or limited evidence about the effects of CON on the cost of non-hospital services, and on the quality and availability of the various health care services.") DANIEL SHERMAN, FEDERAL TRADE COMMISSION, THE EFFECT OF STATE CERTIFICATE-OF-NEED LAWS ON HOSPITAL COSTS: AN ECONOMIC POLICY ANALYSIS, iv, 58-60 (1988) (concluding, after empirical study of CON programs' effects on hospital costs using 1983-84 data on 3,708 hospitals, that strong CON programs do not lead to lower costs but may actually increase costs); MONICA NOETHER, FEDERAL TRADE COMMISSION, COMPETITION AMONG HOSPITALS 82 (1987) (empirical study concluding that CON regulation led to higher prices and expenditures); KEITH B. ANDERSON & DAVID L. KASS, FEDERAL TRADE COMMISSION, CERTIFICATE OF NEED REGULATION OF ENTRY INTO HOME HEALTH CARE: A MULTI-PRODUCT COST FUNCTION ANALYSIS (1986) (economic study finding that CON regulation led to higher costs, and that CON regulation did little to further economies of scale). *But cf.*, COMMONWEALTH OF VIRGINIA, REPORT OF THE JOINT COMMISSION ON HEALTH CARE, HOUSE DOC. NO. 82, STUDY OF VIRGINIA'S CERTIFICATE OF PUBLIC NEED (COPN) PROGRAM PURSUANT TO HB 1302 OF 1996 (1997), ("There is little evidence of significant COPN impact on aggregate health expenditures, but there is evidence of savings for specific services covered by COPN"). *Id.* at 1, *available at* http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/HD821997/$file/HD82_1997.pdf?bcst_scan_129F6A3CDB83467E=xLesgwMDZ3sPV18TUnlHFQAAAD+Q50W&bcst_scan_filename=HD82_1997.pdf (last checked 1/31/08)

[10] CONOVER & SLOAN, REPORT TO MICHIGAN, *supra* note 9 at vii (discussing national and Michigan-specific material regarding acute care [hospitals, MRI services, cardiac services] CON laws); *id.* at 30-31

[11] CONOVER AND SLOAN also report that, "[i]n most states that lifted CON, per capita spending on hospital and physician services (relative to the US) has remained below the U.S. average following removal of CON."). *Id.* at 50; *see also* Christopher J. Conover and Frank A. Sloan, *Does Removing Certificate-of-Need Regulations Lead to a Surge in Health Care Spending?*, 23 J. HEALTH POL'Y & LAW 455 (1998) ("no evidence of a surge in acquisition of facilities or in costs following removal of a CON.") 458

[12] IMPROVING HEALTH CARE, *supra* note 2, at C-8, p. 4 (citing Hosp. Corp. of Am., 106 F.T.C. 361, 495 (1985) (Opinion of the Commission) (stating that "CON laws pose a very substantial obstacle to both new entry and expansion of bed capacity in the Chattanooga market" and that "the very purpose of the CON laws is to restrict entry").

[13] With regard to hospital markets, *see, e.g.*, HHS FINAL REPORT, *supra* note 6, at 10 (reporting "quality of care at least as good as, and in some cases better than, care provided at local competitor hospitals" for

B. Incumbent Lobbying and Petitioning Protections: When new firms threaten to enter a market, incumbent firms may seek to deter or prevent that new competition. Such conduct is by no means unique to health care markets; it is a typical reaction of incumbents to possible new competitors. In certain circumstances, such conduct may violate the antitrust laws.[14] Certain anticompetitive conduct may, however, be shielded from antitrust scrutiny. The *Noerr-Pennington* doctrine immunizes from antitrust liability conduct that represents petitioning the government, even when such petitioning is done "to restrain competition or gain advantage over competitors."[15] Moreover, the state action doctrine shields from antitrust scrutiny many of a state's own activities when a state government is acting in its sovereign, legislative capacity.[16]

In the context of health care competition, the combination of these two doctrines can offer antitrust immunity to providers that wish to lobby state officials to impede the entry of potential competitors, by denying or delaying the CONs required for operation. State CON programs generally prevent firms from entering certain areas of the health

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cardiac care, as well as "very high" patient satisfaction in cardiac hospitals and orthopedic specialty hospitals) (citations omitted). In addition, specialty hospitals appear to offer shorter lengths of stay, per procedure, than peer hospitals. *See* MEDICARE PAYMENT ADVISORY COMMISSION, REPORT TO THE CONGRESS: PHYSICIAN-OWNED SPECIALTY HOSPITALS, 15-17 (Mar. 2005) (hereinafter MEDPAC REPORT). MedPAC was directed to report to Congress on certain issues regarding specialty hospitals under the Medicare Prescription Drug, Improvement and Modernization Act of 2003. *Id.* at vii.

[14] *See* IMPROVING HEALTH CARE, *supra* note 2, at 15-16, ch 1, at 31-33, ch 3, at 22-27.

[15] Andrx Pharm. v. Biovail, 256 F.3d 799, 817 (D.C. Cir. 2001), *cert. denied*, 122 S. Ct. 1305 (2002). The doctrine is named for the seminal cases that treated it: Eastern R.R. Presidents Conference v. Noerr, 365 U.S. 127 (1961), and United Mine Workers v. Pennington, 381 U.S. 657 (1965).

[16] Parker v. Brown, 317 U.S. 341, 351 (1943). The state action doctrine also immunizes from antitrust scrutiny the actions of other entities and individuals if they are acting in furtherance of a clearly articulated state policy and are actively supervised by the state. *See, e.g.*, California Retail Liquor Dealers Assn. v. Midcal Aluminum, 445 U.S. 97, 105 (1980).

care market unless they can demonstrate to state authorities an unmet need for their services. Because that demonstration can be time-consuming and costly, it may delay or, at the margin, prevent the introduction of certain needed facilities and services.[17] Indeed, limiting competitor entry and raising competitors' costs may both be incentives for incumbents to seek to abuse the regulatory process. The FTC/DOJ Report concluded that "incumbents can too easily use CON procedures to forestall competitors from entering an incumbent's market."[18] To the extent they are successful in doing so, incumbents may preserve their market shares and revenue streams without enhancing their own operating efficiency or providing health care savings to the state or its consumers.[19]

C. **The Scope of Alaska CON Law:** Alaska's current CON law is among the most stringent of such laws in the United States. Many CON programs trace their origin to a repealed federal mandate, the National Health Planning and Resources Development Act of 1974,[20] which offered states powerful incentives to enact laws implementing CON programs.[21] By 1980, all states except Louisiana had done so.[22]

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[17] *See, e.g.*, IMPROVING HEALTH CARE, *supra* note 2, at C-4, p. 25 (noting that approval of a CON "can take anywhere from 18 months to several years," and that regulatory delays from CON approval are in addition to those imposed by, for example, traditional licensing requirements).

[18] *Id. at* Exec. Summ., at 22.

[19] *See, e.g.*, MEDPAC REPORT at 10-11 ("Some community hospital administrators admit that competition with specialty hospitals has had some positive effects on community hospitals' operations.")

[20] Pub. L. 93-641, 88 Stat. 2225 (1975) (codified at 42 U.S.C. §§ 300k-300n-5), *repealed*, Pub. L. 99-660, § 701, 100 Stat. 3799 (1986).

[21] *See* JOHN MILES, 2 HEALTH CARE & ANTITRUST LAWS: PRINCIPLES & PRACTICE § 16:1, at 16-2 (2003) (noting that the federal Health Planning Act required providers to "obtain state approval – a 'certificate of need' – before spending set amounts on capital investments or adding new health care services.")

[22] *See, e.g. On Certificate of Need Regulation: Hearing on H.B. 532 Before the Senate Comm. On Health and Human Services* (Ohio 1989) (Statement of Mark D. Kindt, FTC Regional Director).

Congress repealed the federal law in 1986, however, and many states have repealed or revised their CON laws in the years since. Fourteen states have eliminated their CON requirements altogether[23] and, although a substantial number of states continue to maintain CON programs,[24] they do so "often in a loosened form compared to their predecessors."[25] Remaining CON laws may address only specific types of health care facilities – such as hospitals or nursing homes,[26] – exempt certain types of health care facilities,[27] or apply broadly to health care facilities improvements of a greater magnitude.[28] In addition, certain CON laws may be pending repeal according to a sunset provision.[29]

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[23] *See, e.g.*, National Conference of State Legislatures, *Certificate of Need: State Health Laws and Programs* (updated Nov. 2007) (CON laws repealed or not in effect in CA, AZ, NM, TX, KS, CO, UT, WY, ID, SD, ND, MN, IN, and PA), *available at* http://www.ncsl.org/programs/health/cert-need.htm (last checked 01/25/08).

[24] MILLS, *supra* note 21, § 16.2, at 16-9 (stating that "CON laws remain in many states and the District of Columbia"). Quite recently, Florida exempted from CON requirements new adult open-heart surgery and angioplasty programs at general hospitals and the addition of beds to existing hospital structures. Fla. Bill SB 01740 (effective July 1, 2004), *amending* FLA. STAT. ch. 408.036, .0361 (2003).

[25] MILLS, *supra* note 21, § 16.1, at 16-2 to 16-3. *See also* Len M. Nichols et al., *Are Market Forces Strong Enough to Deliver Efficient Health Care Systems? Confidence is Waning*, 23 HEALTH AFFAIRS 1, 11 (Mar./Apr. 2004) (noting that CON programs "eroded through the 1990s").

[26] *See, e.g.*, OAC Ann. 3701-12-05 (2007) (regarding only certain activities by "long-term care" facilities in Ohio), R.R.S. Neb. § 71-5829.03 (2007) (CON covers only certain activities related to long-term care and rehab beds in Nebraska), ORS § 442.315(1) (2005) (regarding "any new hospital or new skilled nursing or intermediate care service or facility" in Oregon, subject to certain exclusions).

[27] For example, Connecticut law exempts critical access hospital beds and related equipment from the State's CON laws. *See* Conn. Gen. Stat. § 19a-487a (2007), *see also* Fla. Stat. § 408.0361 (2007) (regarding cardiovascular services and burn unit licensing), Fla. Stat. § 408.036 (2007).

[28] For example, Connecticut health care facilities must obtain a CON prior to developing, expanding or closing certain services and expending more than $3 million on a capital project. Conn. Gen. Stat. § 19a-638(a)(4) (2007). Delaware requires a CON for the establishment of a new facility, but only for capital expenditures by existing facilities in excess of $5.8 million (or a higher amount based on inflation adjustments to the $5.8 million baseline). *See* 16 Del. C. § 9304 (2007).

[29] *See, e.g.*, 16 Del. C. § 9311 (2007) (sunset provision).

Alaska law requires a CON for any type of health care facility construction or improvement of $1,000,000 or more, adjusted,[30] or the establishment of a nursing home facility independent of that cost threshold.[31] In so doing, it places significant regulatory burdens on the development or improvement of a very broad class of health care facilities – not just major hospital initiatives and expansions, which may be subject to long-term planning – but diverse outpatient clinic initiatives, which might otherwise develop dynamically in response to market needs. The scope of current Alaska law thus stands in contrast not only to the laws of those states that have eliminated their CON requirements altogether, but the laws of the many states that have more limited CON requirements. Alaska's low CON threshold itself may be a special burden to the State's health care spending, as low CON thresholds have been observed to increase costs – relative to higher thresholds – rather than decrease them.[32]

A degree of controversy may remain about particular issues addressed by certain CON laws. These include, for example, efficiency and possible conflicts of interest concerns about certain categories of physician-owned specialty hospitals and access issues for rural or other underserved areas.[33] However, the sweep of Alaska's CON law

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[30] Alaska Stat. § 18.07.031(a) (2007). The statute contains an adjustment provision, whereby the $1 million dollar threshold may be increased by $50,000 per annum, between 2005 and 2014. *Id.* at § 18.07.031(d).

[31] *Id.* at § 18.07.031(b).

[32] *See* SHIRLEY, *supra* note 9, at 58-60 (1.4 percent decline in costs associated with doubling of all thresholds).

[33] *See, e.g.*, Testimony of Mark B. McClellan, M.D., Ph.D. (2005), *supra* note 8; Testimony of Mark B. McClellan, M.D., Ph.D. (2006), *supra* note 8 (regarding CMS studies of physician-owned specialty hospitals, implementation and termination of limited moratorium on new specialty hospitals). The Commission does not here intend to analyze the details of ongoing regulatory reform at CMS designed to address special concerns about certain limited types of specialty hospitals (and related physician self-referral issues) or the various bodies of research on which those reforms are based. The FTC notes, simply,

is much broader than required to address any of those more narrow and complex issues and is likely to be detrimental to Alaska's health care consumers. The Commission recommends that Alaska carefully consider the evidentiary basis of these issues as they may relate to Alaska health care consumers. If the evidence and public policy considerations warrant some legislative action, the Commission recommends that Alaska consider regulation that is narrowly tailored to achieve focused health policy goals instead of broad regulation of entry into the market for health care facilities.

III. Conclusion

CON laws were adopted throughout most states under particular market and regulatory conditions substantially different from those that predominate today and were intended to help contain health care spending. The best available research does not support the conclusion that CON laws actually reduce such expenditures. As the FTC and DOJ have said, "on balance, CON programs are not successful in containing health care costs, and ... they pose serious anticompetitive risks that usually outweigh their purported economic benefits."[14] CON laws tend to create barriers to entry for health care service providers who may contribute to qualitative competition and provide consumers with important choices in the market, but CON laws do not, on balance, tend to suppress health care costs or aggregate health care spending. Moreover, CON laws may be especially subject to abuse by incumbent providers, who can seek to exploit a state's CON process to forestall the entry of competitors in their markets.

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that most of the actual and potential health care entities subject to Alaska CON law are not such specialty hospitals and appear to fall outside the concerns driving those studies and reforms.

[14] IMPROVING HEALTH CARE, *supra* note 2, at Executive Summary p. 22.

Alaska's current CON law – which House Bill 337 seeks to modify – is among the most stringent of such laws in the United States. As a consequence, Alaska CON law creates a barrier to entry for a very broad range of health care service providers, including small health care entities that may be ill-equipped to overcome it. The Commission believes that both the breadth of Alaska's CON law, and its low threshold, are of special concern, as they may work to the detriment of Alaska health care consumers. In the event that adequate evidence develops to support more narrow policy priorities, the Commission believes that Alaska should consider regulations narrowly tailored to meet those priorities, while minimizing the general costs to Alaska health care consumers.

diagnostic
health Anchorage
Discover Excellence in Radiology

March 11th, 2008

AK State Capitol
House Finance Committee
Juneau AK 99801-1182

Dear Representative Chenault, Representative Meyer, Representative Stolze and other House Finance Committee members

As an AK resident and healthcare administrator I implore you not to consider any legislation or portion thereof (i.e. HB 327, HB 337A/B, and HB 345), which recommends removal or modification of AK's Certificate of Need (CON) program. Thorough and unbiased research needs to be accomplished prior to any such action given the potential negative impact such legislation would have on the safety and quality of AK's healthcare.

I currently serve as the AK Area Administrator for Diagnostic Health and directly oversee a full modality outpatient imaging center located in midtown Anchorage[1]. As a healthcare administrator with over 15 years of experience, I have grave concerns regarding current legislation in the Senate and House to eliminate or modify AK's CON program. I strongly urge unbiased research/study to determine the full short-term and long-term impact before any such action is taken. Some particulars which need to be contemplated are as follows:

- Thirty-six states still maintain some form of a Certificate of Need program. Many of the states that repealed their laws in the 80s and 90s experienced a proliferation of facility development and major medical equipment acquisition. This is particularly disturbing given that "supply" for outpatient imaging services (in the Anchorage area) is currently greater than "demand."
- Removing/modifying AK's CON program could have an extremely negative outcome with regard to quality of care as many freestanding imaging centers would not bother to hire registered technologists or ensure their facility is accredited. The American College of Radiology is conscious of this fact and thus tends to favor tighter CON restrictions for imaging services.
- Removing/modifying AK's CON program would certainly have an immediate and possibly long-term impact on the availability of skilled labor (registered technologists) causing shortages in many fields/modalities with the strong probability of negatively impacting the safety and quality of AK's healthcare.
- Market and business-driven healthcare in AK is idealistic but not a reality. It's a contradiction for some to say that "health care must be market-and business-driven, rather than restricted by government" when reality illustrates that healthcare is the most

[1] Diagnostic Health Anchorage LP (formerly HealthSouth Diagnostic Center of Anchorage LP) has been providing full modality outpatient imaging services in a timely, quality, and cost-effective services to AK residents for over 10 years.

heavily regulated industry and that government dictates a significant portion of most healthcare entities reimbursements.

As a member of the CON Negotiated Regulation Making Committee (Oct/Nov 2007) I had hopes that state officials would use the Committee's recommendations in making the necessary changes to AK's CON program. I can attest that the Committee was a solid cross-sectional representation of our state's finest healthcare leaders. As you are aware, reaching 100% consensus whether it be the Committee or AK Legislature is never accomplished. Therefore, the Committee agreed upfront that 66% or greater was the determinate number to say that a consensus was reached, if 70% or higher was reached the decision would be considered a high consensus. What was amazing is that 88% of the committee determined that the state of AK needed to retain the CON program; 83% determined that imaging services needed to remain in the CON requirements. An important point to highlight is that the Achilles Heal for the state is not the CON program itself. The Achilles Heal has been the inability to define in regulation what a "physician office" is. Not adequately defining physician office has created a tremendous amount of litigation for the state. Realizing the import of this issue, the Committee clarified the definition of physician office with 71% of the committee stating that a physician office should be 100% physician owned." What perplexed me and other healthcare providers who took their valuable time to participate in the CON Negotiated Rule Making Committee is that our recommendations to address the obvious CON issue didn't seem to satisfy our Governor or the Commissioner of the Department of Health and Human Services. Within weeks of the Committee's final report, the Governor introduced the Alaska Health Care Transparency Act of which a component there within proposes to completely repeal the CON program.

I appreciate some aspects of the AK Health Care Transparency Act; however, repealing or modifying the Certificate of Need program at this time would be premature and could have severe negative consequences to the safety and quality of Alaska's healthcare. I urge AK Legislatures to table any discussion regarding the CON program until unbiased research and recommendations are provided. Please contact me if you have any questions or concerns at ward.hinger@dxhealthcorp.com or (907) 729-5854.

Sincerely

Ward Hinger
AK Area Administrator for Diagnostic Health

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES
OFFICE OF THE COMMISSIONER

SARAH PALIN, GOVERNOR

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February 25, 2008

Honorable Peggy Wilson, Chair
House Health, Education, and
Social Services Committee
Alaska State Capitol, Room 403
Juneau, AK 99801-1182

RE: House HES Committee questions on House Bill 337, House Bill 345, House Bill 407

Representative Wilson:

In response to questions raised by the House Health Education and Social Services Committee on Saturday, February 23, 2008:

Questions regarding Certificate of Need:

Please clarify how capital costs play into rates and how CON controls the rates for RPTC and Nursing Homes.

For nursing homes, CON approved capital costs for projects with approved capital costs over $5 million are included in the calculation of payment rates immediately upon the new project beginning normal operations. For CON approved projects costing less than $5 million, the approved CON capital costs are included in the calculation of rates when the individual facility's payment rate is rebased. If a project that requires a CON does not receive an approved CON, those costs are never included in the Medicaid payment rate.

To clarify, CON controls the Medicaid rates for Nursing Homes by only including capital costs to be included in the Medicaid cost-based rate if a required CON has been approved, and initially only to the capital costs approved in the CON.

And, currently, CON does not directly affect the Medicaid payment rates for RPTC. RPTC payment rates are based on cost studies that include consideration of capital costs, but those rates are not based upon whether or not an RPTC has an approved CON.

When using a specific threshold for population base, as in HB345 at 60,000, do we need to define so that it is clear whether it includes military and tribal?

We should define the population in statute so it is clear either way. The department believes we should exclude IHS and Military in CON population threshold.

Questions on information collected by the Information office and disseminated on the state Web Site:

Do we want an amendment whereby physicians would need to report costs/rates to the health information office for posting on the Web site?

We will need to make sure that the Information Office has the authority to collect such information; should the committee wish to have this information collected and on the Web site, it should be clarified in statute.

Do we want an amendment that indicates who accepts Medicaid and Medicare in the information new collect?
We would support having this information on the Web site, although should the committee wish to have this information collected and on the Web site, it should be clarified in statute.

Does the commission have the ability to add to the information collected and provided to the public new services/facility types that have not yet been developed?
There are difficulties in including emergent technologies in the bill – we recommend giving the Commission the option to recommend inclusion of information on new types of services through future statutory changes.

RE: composition of the Health Care Commission
The Administration supports the composition and duties of the Health Care Commission as proposed in **HB407**. We would support incorporating in those elements into HB337, rather than have the Commission be legislated separately from the Health Information Office and repeal of the Certificate of Need. We still believe that the three parts of HB337 better provide for support to the Commission by the department, and provides for needed change in the Health Care system by repealing Certificate of Need.

Technical amendments:
With the permission of the HES Chair, the Departments of Law and Health and Social Services can work with Legislative drafters to clear up technical problems in the legislation.

Sincerely,

Sherry Hill
Assistant Commissioner for Public Affairs

Cc: Representative Paul Seaton, Room 102
Representative Bob Roses, Room 416
Representative Anna Fairclough, Room 411
Representative Wes Keller, Room 24
Representative Sharon Cissna, Room 420
Representative Berta Gardner, Room 422
Karleen Jackson, Commissioner
Dr. Jay Butler, DHSS Chief Medical Officer
Mike Tibbles, Chief of Staff, Governor's Office
Anna Kim, Special Assistant, Governor's Office

Russell Kelly, Director, Governor's Legislative Office

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Certificate of Need Laws: Why It's Time for Repeal

Dr. Roy Cordato
Introduction by Dr. Michael Morrisey

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Certificate of Need Laws: Why It's Time for Repeal
by Dr. Roy Cordato

Introduction by
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Introduction

Dr. Michael A. Morrisey

Certificate of need (CON) is an amazing program that requires hospitals, nursing homes, and usually other medical facilities such as ambulatory surgery centers and diagnostic imaging facilities to have the explicit approval of the state before they can operate. It originated in New York State in 1964 and became national policy during the Richard Nixon administration. The legislation was intended to control rising healthcare costs that resulted from cost-based reimbursement. CON was repealed as national policy during the Reagan administration -- some 20 years ago.

What is amazing is that there is virtually no rigorous empirical evidence that the program has been effective in reducing hospital or healthcare costs and some evidence that it increases costs. This was true in the heyday of the program in the 1980s and is still true in more recent evaluations. Yet, CON continues to exist for hospitals in Alabama and 25* other states and effectively limits hospital construction and renovation.

In this report Roy Cordato does a masterful job of describing the wonder of CON – the evidence of ineffectiveness, the record of bureaucracy and delay, the stifling of innovation, and the limits to competition in healthcare. It should be read by anyone interested in reducing healthcare costs, increasing competition, thereby empowering healthcare consumers, and reducing unnecessary government agencies.

I want to highlight four points for Alabamians to consider. First, we don't save money as a result of the CON program. There is essentially no evidence that healthcare

* There are 26 states with CON programs for hospitals. There are 35 states with a CON program applicable to some type of medical care facilities and/or equipment

costs are reduced. Cordato carefully documents this. Currently, hospitals and other protected providers argue that CON keeps new providers from coming in and taking the profitable patients. It certainly does. Another way t say this is that the existing providers are collecting prices that are higher than their costs and apparently higher than the new entrants would charge. So, by their own admission, we pay higher prices.

Second, we have less choice and less innovation. In the spring of 2007 our neighbors in Georgia witnessed a long and bitter battle waged in the legislature over amending or repealing its CON law. On one side were hospitals arguing to keep CON intact. On the other side were physician groups arguing to be allowed to open freestanding ambulatory surgery centers and other outpatient facilities without having to go through the burden of the CON process. The hospitals won this battle when the legislature deadlocked and took no action.

Entry of new ambulatory surgical providers is no trivial issue. We all have friends or family members who have had an ambulatory procedure performed that only a few years ago would have required a day or more in the hospital. The American Hospital Association reported that in 2004 there were over 1.7 outpatient surgeries conducted in U.S. hospitals for every one hospital surgery that required an overnight stay.[1] Ambulatory surgery centers represent a competitive alternative to hospitals for these outpatient procedures. Indeed, my research suggests that nationally every freestanding ambulatory center per 100,000 population in a metropolitan area is associated with a reduction of 4.3 percent in the number of hospital-based outpatient procedures.[2] The battle in Georgia was over entry of new providers and choice and ultimately over who gets the patients. As Cordato makes crystal clear in this monograph, in states like

Georgia, North Carolina and Alabama the CON agency plays a big role in deciding who gets the patients and what access those patients have to new technology.

Third, CON is not only focused on keeping out new forms of healthcare delivery, it is also concerned with whether and how existing providers can serve their communities. One need look no further than the burgeoning Highway 280 corridor in Birmingham or the growth in Madison County near Huntsville to appreciate that many people in increasingly congested areas of the state now have longer travel times to get to a hospital. In both communities, existing hospitals (and new providers) would almost certainly be willing to build in the growth corridor. Much of what stops them is the CON process. Any proposed action will be opposed by other hospitals in the community because of the threat to their established patient flow. So, in addition to the usual construction and operating costs, an effort to expand will be tied up with CON hearings, decisions, appeals and more appeals.

There is no better example of provider opposition than Brevard County, Florida, near Cape Canaveral. Wuesthoff Hospital and Health First Hospital have been competitors in this fast growing community for years. In 1997 Wuestoff proposed to build a second hospital. It obtained an CON approval that was opposed by Health First in the courts. It was only in 2000 that Wuesthoff finally cleared the legal challenges and the new facility opened in December of 2002. Ironically enough, Health First Hospital later applied for a CON for its own new hospital. After getting a CON in late 2005, the approval was opposed by Wuesthoff. Health First's final approval was not obtained until April of 2007 and the new facility is expected to open in 2010.[3] Thus, the opposition fostered by the CON process resulted in delays of three years in the first instance and

nearly two years in the second. In other cases, undoubtedly the Highway 280 case as well, providers don't even try because of the time and cost of fighting for approval.

Finally, Alabamians needn't be reminded of the embarrassment of a former governor and a former hospital CEO who were convicted in a federal bribery case associated with an appointment to the Alabama CON board. We are not alone, of course. In 2006 a member of the Illinois CON board pleaded guilty in federal court to accepting kickbacks associated with steering business to a construction contractor when a suburban hospital sought a CON approval. He was also charged with being instrumental in denying the application of another hospital that did not hire the contractor.[4]

Regulatory agencies that provide protection from market competition and thereby offer the potential for substantial profits are tempting targets for unscrupulous politicians and bureaucrats. These temptations can be overcome with sufficient monitoring and careful processes, but it seems foolish to go through all of that for a program that doesn't provide benefits to the citizens of the state.

The CON program never controlled costs and has become a mechanism to limit competition in healthcare, making all of us worse off. I encourage you to read Roy Codato's report and judge for yourself. It's time for repeal.

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Certificate of Need Laws: Why It's Time for Repeal

Dr. Roy Cordato

What's Wrong with this Picture?

Imagine an economic system where market competition is viewed as a wasteful activity that needs to be discouraged or even prohibited by government. In such a system, for example, if a Chinese immigrant family wants to open a restaurant, they first have to go to a government commission that will survey the economic landscape for Chinese restaurants to determine if there already are "enough" such eateries in the area. The commission might have a formula that looks at data regarding how many Chinese restaurants exist per 100,000 or 50,000 or 25,000 in population; how many of those are strictly take-out restaurants and how many are eat-in or "sit down" restaurants; and among those that are sit-down style, how many feature buffets and how many are strictly order-from-menu. The formula might also consider variations in price from restaurant to restaurant to determine how many are serving lower-income families and how many are targeted to the gourmet Chinese food market.

After going through all this--a process that might take several years--the commission will then decide whether this particular Chinese restaurant is "needed" in the area. If it is not, this immigrant family will then be sent packing to find another way of earning a living. Or, it might be suggested that they try some other area where it has been determined there are too few Chinese restaurants to adequately serve the existing population.

If it is determined that, yes this community indeed does "need" one more Chinese restaurant, a "certificate" will be issued to the immigrant family. It could state that a

restaurant of this type and size is "needed" and that the family has permission to set up shop. But of course the restaurant will have to be built to the exact specifications described in the original proposal that was ultimately approved. It may not be able to offer take-out service if there are already "enough" take-out restaurants in the area. It will have to be built only to accommodate a certain number of tables because any more or any less will not fit the need as determined by the formula. The menu will have to be approved, because if the restaurant is also going to serve non-Chinese foods such as pizza or hamburgers—for those who might not like Chinese food—that will fall into a different category and those menu items will have to be passed through another formula and another process.

Most people look at such a system and think "this is crazy, only an old Soviet-style central planner could be happy with such a bureaucratic nightmare." Besides, we all understand it is competition that makes the consumers in the marketplace better off. Competition brings lower prices, more convenience, better quality, new technologies and innovations, and so on.

The system as described above will have its beneficiaries. Government workers charged with running the system clearly can do well because of its existence. But beyond this, what about existing restaurateurs who have already received one of these highly valued certificates and are operating a flourishing business? Wouldn't they like the idea that the local government had an entire division devoted to protecting them from competition? Wouldn't it be nice to not have to worry about customers being taken by some upstart Chinese restaurant with lower prices or fancier foods on its buffet? Sure, restaurant customers would probably be better off if anyone who wanted to could simply

start a new restaurant, but people aren't aware of what they are not getting. Some customers might look around and say "gee the town already has a couple of Chinese restaurants and there's never a wait to get in, so why is there a need for another one? Certainly a new one would be wasteful."

Of course this would be said without knowing what a new restaurant would be like, what menu items it might offer, what prices it might charge, etc. Because people don't know what they don't know, even the consumers, who are always hurt by monopolies, might end up supporting this system.

The Reality of Certificates for Medical Care

The system described above is exactly the kind of system that Alabama and 35[1] other states have with respect to medical care facilities and equipment. If you are a healthcare entrepreneur and you want to do anything from adding a new wing or extra beds to an existing hospital, to opening an office that offers MRI, X-ray or other services, you need a "Certificate of Need" from the state. The function of Alabama's CON is summarized as follows:

"No certificate of need for new inpatient facilities or services shall be issued unless the State Health Planning and Development Agency (SHPDA) makes each of the following findings:

1) That the proposed facility or service is consistent with the latest approved revision of the appropriate state plan effective at the time the application was received by the state agency;
2) That less costly, more efficient [illegible] appropriate alternatives to such inpatient service are not available, and that the development of such alternatives has been studied and found not practicable;
3) That existing inpatient facilities providing inpatient services similar to those proposed are being used in an appropriate and efficient manner consistent with the community demands for services;

[1] See footnote on page 1

4) That in the case of new construction, alternatives to new construction (e.g., modernization and sharing arrangement) have been considered and have been implemented to the maximum extent practicable; and
5) That patients will experience serious problems in obtaining inpatient care of the type proposed in the absence of the proposed new service."[5]

If this sounds like the kind of central planning one might find in a socialist economy—it is. In Alabama, the central planning authority is known as the State Health Planning and Development Agency (SHPDA) The role of this agency is to plan economic activity provided by medical care facilities. This is done down to the most minute detail, circumventing the most basic function of private decision-making in a free enterprise system, i.e., the allocation of resources based on entrepreneurial insight and risk-taking.

The purpose of HPDA in implementing CON is to "develop policy, criteria, and standards for health service facilities planning; conduct statewide registration and inventories of, and make determinations of need for health service facilities, health services as specified [in the statute] and equipments as specific [in the statute], which shall include consideration of adequate geographic location of equipment of services; and develop a State Medical Facilities Plan " The Agency also has the authority to review all records in any recording medium of any person or health service facility subject to agency review under these articles which pertain to construction of acquisition activities, staffing or costs and charges for patient care, including but not limited to, construction contracts, architectural contracts, consultant contracts, purchase orders, cancelled checks, accounting and financial records, debt instruments, loan and security agreements, staffing records, utilization statistics and any other records deemed to be reasonably necessary to determine compliance.

Alabama's Certificate of Need Law is, with few exceptions, an all-inclusive and all-intrusive blueprint for state government control of all supply and pricing decisions with respect to the provision of institutional healthcare facilities. The process that a potential hospital, nursing home, clinic, doctor's office or other supplier must go through to receive a CON is tedious and potentially very long. Depending on the number of reviews the process can take anywhere from 90 days to over two years. If a denial is appealed to the state Court of Appeals, the process can go well beyond this two-year period.

It is quite clear that most important aspects of the production, distribution, and sale of healthcare services in Alabama, and most other states, have been removed from the competitive free enterprise system and placed under the authority of a command and control government bureaucracy. And like all other bureaucracies, it promotes factionalism and division and allows some groups and institutions to suppress the activities of others. The market is run by government fiat rather than entrepreneurial insight and patient preferences.

History, Justification, and Application of CON

The origins of CON in Alabama, and many of the other states that have such a system, rest in a long since repealed federal government mandate. In 1974, Congress passed the National Health Planning and Resources Development Act. The Act stated that in order to receive federal funding from programs like Medicare and Medicaid, new healthcare facilities, and additions to existing facilities, needed approval from a state

agency established to issue certificates of need. All states were told to have such programs in place by 1980. This was seen as a way of controlling healthcare costs.

At the time, reimbursements for services were being made on the basis of costs of production. It was thought that facilities were being built and equipment was being purchased unnecessarily simply because the hospitals knew the facilities would ultimately be paid for through increased fees. In a market setting where healthcare providers need to compete for cost conscious purchasers of services, even if those purchasers are insurance companies, higher costs cannot simply be passed along in higher prices.

New facilities would be built or new equipment would be purchased only if the market prices for the services that would be generated could justify the added costs. Expansions would be made only if it was thought they could be justified by actual demand. This is what entrepreneurship is all about: spotting actual or potential unfilled demand and organizing resources in new ways in order to meet it. If the demand is not there, losses will be incurred and plans would have to be revised. The government payment system at the time did encourage inefficient investment because it took the risk out of the process.

Costs were recouped regardless of any shortcomings in accurately estimating demand. Indeed the so-called "cost plus" system of reimbursement took away the need to consider future demand at all. The result was a classic case of an initial government intervention into market decision-making--in this case the Medicare and Medicaid programs--creating distortions of its own. These, in turn were used to justify additional

interventions: the CON program. As is typical, the new interventions lead to their own set of problems.

In 1987 Congress repealed its mandate and stopped subsidizing states that implemented it. This came after the federal government abandoned its Medicare cost-based reimbursement system and switched to paying a predetermined amount based on the kind of treatment. Since that time, 14 states have dropped their CON program, allowing for competition. Alabama is one of 36 states, plus the District of Columbia, that continues with centralized planning of the healthcare-facilities market.

Although cost containment, as noted, was and continues to be the primary justification for CON, there are other reasons given for keeping these laws in place. The most prominent are related to the provision of care for the indigent and include the arguments that:[6]

- Removal of CON will place a greater burden on the disadvantaged. The fear is that market forces will lead to certain segments of the population and those living in rural areas being underserved.
- Removal will favor for-profit hospitals, which may be less willing to provide indigent care.
- Removal will lead to a proliferation of "low volume" facilities, which are associated by some with lower-quality care

As a historical footnote, in the 1960s and early 1970s, prior to the federal mandate, more than 20 states had decided to implement CON laws independently, allegedly for cost-control reasons. According to Charles Gaffna, writing for the Federal Reserve Bank of Richmond, these pre-mandate laws were implemented "in response to

hospital operators who favored centralized health planning."[7] This is consistent with the economics of CON, to be discussed below, which suggests that in reality, CON is a cartel enforcement device that protects incumbent providers from new entrants and competition.

According to East Carolina University researchers Campbell and Fournier, "there are reasons to suspect that CON may have been adopted for other purposes … the states most likely to enact CON … were those with a highly concentrated hospital industry and increasing competitive pressures … hospitals were largely in favor of CON regulation, which is understandable considering that it protected them from competition."[8] Much like existing restaurant owners in our opening example, having a government bureaucracy whose goal is to protect your business from upstarts is a nice perk.

In reality, the continuation of CON regulations cannot be justified either theoretically or empirically. In fact, from the perspective of sound economics, the reverse is true. If one desired to devise a policy for any market whose purpose would be to reduce efficiency, raise costs and prices, and reduce product quality, the existing CON programs would be highly recommended.

If You Like OPEC, You'll Love CON

When it comes to crude oil, it is indisputable that the ability to raise prices and therefore energy costs rests with the power to restrict output and production. When President Bush met with Prince Abdullah of Saudi Arabia on April 25, 2005 to discuss high oil prices, the question immediately turned to the Organization of Petroleum Exporting Countries (OPEC) which raises prices by restricting production. Saudi Arabia,

the largest oil producer in the world and the leader of OPEC, is seen as having the power to expand production and bring prices down.

For those who support CON laws it is thought that medical-care markets operate in the exact opposite manner, that the way to keep costs down is to restrict the supply of medical facilities and equipment. For example, if the intent is that MRI services should be less expensive, we should have fewer MRI machines; or if we want hospital stays to be cheaper, we need fewer hospital rooms. As pointed out by The National Academy of State Health Policy in describing CON regulations: "Efforts to control the supply of services are well demonstrated by state Certificate of Need programs, which seek to limit the acquisition and dissemination of substantial investments in technology and capacity. These limitations are imposed in an effort … to hold down the volume of services provided and the cost."[9] But it is just as wrong-headed to think that limiting the supply of healthcare equipment and facilities can reduce healthcare costs as to think that oil prices could be reduced with further reductions in oil production.

There is possibly no proposition in economics that is more accepted than the idea that if you want to reduce the cost of something, you foster an environment that encourages open competition and entrepreneurship and discourages monopoly. But the role of competition goes well beyond this. Rivalry among businesses--and healthcare providers are no exception--stimulates new technologies and innovative and more efficient ways of delivering goods and services to customers. Existing providers continuously have to keep their costs low and their products desirable in order to fend off potential competitors looking for an opportunity to earn profits. These potential

competitors, like the neurologists discussed above who wish to provide MRI services, are always looking for ways to outperform existing providers.

As noted, CON laws turn the simple economic truths about the relationships between competition and lower prices and higher quality on their head. Proponents of CON laws do not refute the economics by presenting an alternative economic framework that would explain why an actual free market in medical care facilities and equipment would not behave as economic theory would predict. Instead they suggest that standard economics should not be used as the basis for analysis at all, even though what is being assessed is at the heart of what economic science is about—market price and output formation and the efficient allocation of scarce resources.

For example, The American Health Planning Association (AHPA), in criticizing a recent report by the Federal Trade Commission (which I discuss in the next section), disparagingly notes that the FTC grounds its opposition to CON laws in "orthodox economic doctrine." The AHPA suggests that to rely on standard economic theory, as opposed, I presume, to some non-orthodox economic theory or possibly some other social science, is to ground the analysis in "an article of faith."[10] This would be comparable to complaining that much of medicine and the analysis of patients' conditions by doctors is also mistakenly grounded in "orthodox" theories of biology and human anatomy.

In large part, the idea that increased supply leads to higher prices and costs stems from a basic premise that is clearly false; namely that service duplication within a geographical area (defined by government planners) is inefficient and therefore cost enhancing. In justifying Alabama's law, it is stated that "the costly proliferation of *unnecessary* health service facilities results in *costly duplication* and *underuse* of

facilities, with the availability of excess capacity leading to *unnecessary* use of expensive resources and *overutilization* of healthcare services."[11] [Emphasis added] First, note the presumptuous and paternalistic attitude of the legislators formulating this statement. They claim to know better than healthcare consumers, their doctors, and facility operators, how "necessary" facilities are and that these market participants are "overutilizing" the healthcare that is available to them.[12] It should also be noted that the utter confusion of this statement is demonstrated by the fact that in the same sentence, it claims the free market somehow leads to both "the *underuse* of facilities" and the "*overutilization* of healthcare services."

But more importantly, in a fundamental sense the statement is proclaiming that monopoly is good. Facility duplication is at the heart of competition. Indeed, the definition of a monopoly market is one where there is no duplication. And this is why customers in monopoly markets lose. They are denied the option of turning to others who are providing "duplicated" services when the monopoly providers act like monopolists. This is essentially the debate going on before an administrative law judge in Montgomery. Which hospital, Crestwood Medical Center or Huntsville Hospital, will be allowed to build a new facility in the fast growing Huntsville, AL market?[13]

Apparently, some state bureaucrats, who are not market participants themselves, believe there would be excess capacity if new providers are allowed to enter the market. But the concept is meaningless. For example, because many Chinese restaurants, at a point in time, have empty tables, or some movie theaters have empty chairs, it doesn't mean there is inefficient excess capacity of restaurants or theaters. New facilities and services would lead to more choices for patients and more competition for their

healthcare dollars. Indeed, at the lower prices that could be generated, people who might forgo health exams for less expensive, but also less effective methods of diagnosis may be able to take advantage of the more advanced technology. What is and isn't excess capacity has to be determined in the marketplace and will be revealed through the system of profit and loss. Certainly there is no way for a healthcare central planner to second-guess the correct result.

The Evidence on CON and Costs

Not surprisingly, the evidence matches the economic theory. Since the 1980s when states were set free from the federal requirement to have CON laws, numerous studies have examined the change in healthcare costs as states eliminated their laws. If CON were "working" as advertised, then one would expect to see a rise in healthcare costs when the laws were eliminated. But this is not the case. One of the most recent and widely referenced studies was written by Duke University Professors Christopher Conover and Frank Sloan and published in 1998 in the *Journal of Health Politics, Policy, and Law*.[14]

Their results are consistent with "orthodox" economics. Output restrictions lead to higher, not lower costs and higher profits for existing providers. The authors point out that for hospitals, CON laws resulted in a 2 percent reduction in bed supply *and* "higher costs per day and per admission, along with higher hospital profits," exactly what economic theory would predict. The study did find a modest reduction in per capita "acute care" spending, which it attributed to CON laws. Interestingly, the study "was unable to detect a statistically significant effect of removing CON on these same

expenditures." But overall, the study found no decrease in per capita healthcare spending attributable to CON.

An earlier study showed even more dramatic results. This study examined data through 1982 and found that CON was associated with a 20.6 percent increase in hospital spending and a nine percent increase in spending on other healthcare. Overall, the study found that CON was responsible for a 13.6 percent increase in per capita spending on personal healthcare services.[15]

Over the last two decades, the FTC has done several studies on the impact of CON laws, both nationally and for specific states. The FTC's consistent conclusion can be summarized in the language from its most recent study released jointly with the Department of Justice in July 2004. "The Agencies believe that CON programs can pose serious competitive concerns that generally outweigh CON programs' purported economic benefits. Where CON programs are intended to control healthcare costs, there is considerable evidence that they can actually drive up prices by fostering anticompetitive barriers to entry."[16]

In 1989, similar testimony was given to the North Carolina Goals and State Pol[illegible] Board by FTC staff. The staff testified that "evidence does not support the view that Certificate of Need regulation reduces the costs of providing healthcare services … consumers would most likely be better served if CON regulations were removed."[17] As one study reports, "in researching the scholarly journals, one cannot find a single article that asserts that CON laws succeed in lowering healthcare costs."[18]

CON as a Hidden Healthcare Tax

While the discussion to this point has focused on the economics of CON, it should be pointed out that there are other fallback arguments for these regulations that relate to the provision of care to the indigent. Oddly enough, the arguments from this perspective actually contradict the "cost saving" case for CON. The argument is that entry restrictions, and the higher prices and profits that go along with them, are necessary to induce providers to provide free indigent care. As summarized in a study by Campbell and Fournier, "CON policies have … been pursued with the implicit aim of 'cross subsidization,' that is, regulators have used their power to issue licenses and restrict competition in order to create an incentive to hospitals to provide high levels of care to the indigent population."[19]

What this means is that CON laws are used to create a hidden tax. The cost of healthcare and the profits to healthcare providers are purposely kept high by granting monopoly privileges. It is then expected that these excess profits will be used to provide free healthcare to the indigent. Healthcare customers are forced to pay a premium created by CON laws and the proceeds from this premium are used to pay for indigent care. If nothing else, this is dishonest. If a social and political goal is to see to it that those who cannot afford healthcare have their needs taken care of, then the costs of that policy should be up front and explicit. This is the only way the electorate can make informed decisions regarding public policy. If it is deemed that those who are paying for healthcare services should bear the burden of also paying for care given to the indigent, then an explicit excise tax should be placed as a line item on all healthcare invoices, and CON laws should be abolished. If CON laws are being used to hide this tax from the electorate,

then not only are they inconsistent with sound economics; they are also inconsistent with an open and democratic political process.

Another way in which CON imposes a hidden tax on the healthcare system relates to the resources hospitals and other healthcare entrepreneurs must devote to obtaining the certificate. The process of obtaining a CON is not only time consuming but expensive. The ill-fated U.S. Highway 280 "hospital" in Birmingham provides an excellent example. The facility stands empty in large part because no new private entity believes they can obtain a CON and no current market participants believe it is worth the fight with its sister hospitals to try to open a new hospital in the high growth 280 corridor. The experience in Madison County, near Huntsville is also instructive. Local Huntsville hospitals are "competing" to get the SHIPDA, the Alabama CON agency to designate one and only one of them as having the right to build a new facility.

Healthcare Policy: Breaking the Consumption/Payment Link

Is healthcare over-priced? In many, if not most cases, the answer is yes. But this is not a problem that CON regulations can address. In fact, as argued previously, such laws are likely to contribute to the problem. The reason why healthcare may be overpriced is that, in most cases, what economists call "the consumption/payment link" is broken.

Because of government entitlement programs and the nature of modern health insurance, most people do not directly pay their own healthcare expenses. In 2002 over 84 percent of all personal healthcare expenditures were made by someone other than the person receiving the care.[20] Unlike the market for other goods and services, healthcare is consumed by the patient and, minus a co-pay or deductible, paid for by state and local

government or by an insurance company operating a healthcare plan. Hence, the "consumption/payment link" that is typical of most other buyer/seller arrangements, is broken in the healthcare market.

How is healthcare like an all-you-can-eat buffet or a free shopping spree?

This arrangement causes healthcare to be overpriced because it leads to healthcare being over-consumed. People will generally consume more of any product when the amount paid is unrelated to the amount consumed. Furthermore, they will consume relatively more of what would otherwise be the highest-priced or higher-valued options. This is why people tend to "overeat" at all-you-can-eat buffets. It also explains why, when crab legs or sirloin steaks are on the buffet, people will tend to consume relatively more of those items than the hot dogs or beans.

Imagine a grocery store operating like the healthcare system. Instead of walking up and down the isles seeing different prices for different food items and making tradeoffs between prices and different kinds of products, we were all on an employer-paid-for "food insurance" plan. Whenever we needed groceries, we would drive to the local supermarket and pay a fixed co-pay at the door. Once inside, we could simply take all the food products we "needed." As a food consumer, how might we behave? Would we take only "what we needed" or all that we could carry out? Would we go directly to the hot dogs and canned beans or would we find ourselves eating significantly more filet mignon and lobster? Clearly, the "purchase" of food overall and the proportion of lobster and high-priced cuts of meat relative to hot dogs and beans would increase. This would send the overall price of food and the "food insurance" premiums and co-pays through the roof. This is exactly what has happened for decades in the healthcare market.

The Problem of Low Deductibles

The fact that many plans have low deductibles with routine healthcare problems being paid by insurance, rather than only high-cost operations and catastrophic conditions also fuels the costs of healthcare. In the 1940s, '50s, and '60s, most people referred to healthcare insurance as "hospitalization insurance." This is because insurance mostly covered high-cost health problems that required operations and stays in the hospital. The effect of what is now called "first dollar coverage" or near first dollar coverage, i.e., plans with very low deductibles, can be seen if we imagine the effects of auto insurance that not only covered damage from accidents, but oil changes and tune-ups as well. If people showed up for an oil change and showed the mechanic an insurance card, the service shop would clearly be less concerned about keeping the price competitive, and the car owner would be less concerned about getting the best deal. The prices of oil changes, tune-ups, etc., would be much higher than they are today.

Isn't the Free Market Failing?

The current consumption and payment arrangements are not the result of a free market for healthcare, but a failed set of government policies. As noted, most people do not pay directly for their own healthcare, but it goes beyond that. They don't even pay directly for, or even own their own health insurance policy, like they do with auto or homeowners insurance. Taxpayer-funded programs like Medicare and Medicaid pay nearly 45 percent of all healthcare bills.[21] The rest is mostly paid for by group health insurance policies that are owned by employers. For most types of insurance, such as auto, homeowners, and life, premiums are associated with the risks posed by the owners of the policy, i.e., those who are covered by the policy. The problem of over consumption

is tempered by the policy owner's desire to keep his or her premiums low. This market check is not in place for health insurance. Those who are insured are not paying individual premiums for their insurance, and the amount being paid in premiums is not related to the risk associated with insuring individual policyholders. As noted, with few exceptions, there *are* no individual policyholders.

All the usual checks that would occur in a free market are missing. There are a number of reasons for this but the most important is related to the way health insurance is treated for income tax purposes. The tax code penalizes the individual ownership of health insurance policies and encourages the ownership of group policies by employers. Since WWII, health insurance provided by employers is considered a tax-free benefit to the employee, while personally owned health insurance plans must be paid for with after-tax income.[22] This has led to very generous and expensive low- or no-deductible plans offered by employers. In many cases a tax-free dollar offered in the form of a low- or no-deductible health insurance benefit is more valuable to an employee than a taxable dollar offered in the form of wages. So we end up in a situation where public policy has led to an overuse of health insurance and healthcare services.

There is some good evidence that competition actually has worked in healthcare. The evidence comes from the workings of managed care in the first half of the 1990s. Now most people tend to think of managed care as their primary care gatekeeper denying them access to a specialist or to a longer hospital stay or to a particular drug. Managed care plans have done these things – but ironically there is remarkably little evidence that these activities lowered costs.

However, the real contribution of managed care was (and is) selective contracting, not these ineffectual utilization controls. Managed care plans negotiated contracts with hospitals and other providers based upon quality, and location *and price*. What the evidence shows is that when there were more hospitals in a market, the managed care plan was able to negotiate lower prices. Given the number of hospitals, when there was more idle capacity in the market, the managed care plans were able to get still lower prices. The managed care plans were also able to get lower prices when they had a larger number of enrollees in the market. Thus, consistent with orthodox economics, managed care plans were able to use patient volume to drive lower prices - and this process was more successful when there were more providers in the market.[21] The "managed care backlash" has focused on the utilization controls and ignored the selective contracting with the result that we moved from declining health insurance premiums in the mid 1990s to increasing premiums today.

A public policy answer to this problem is arriving, albeit tentatively and slowly, in the form of "health savings accounts" (HSA), which were made legal as part of the Medicare Reform Act passed in 2003. The entire point of these accounts is to reconnect the consumption/payment link. These plans allow employers to offer high-deductible insurance plans to their employees, which have lower premiums. The employer then deposits a fixed amount each year into an individual HSA that is owned by the employee and where both the amount deposited and any interest earned is tax exempt. The money in this account can be used to pay for expenses up to the deductible, as well as other healthcare costs. In addition, any amount left in an HSA can be willed to the owner's heirs, who are not required to use this money for healthcare expenses. The important

point is that any amount from this account not spent remains the property of the employee, to be used for either future healthcare problems, retirement income, or to leave to their children and grandchildren.

This approach reconnects consumption and payment for most routine healthcare-related costs. A dollar spent on healthcare services now is a dollar that cannot be used later. As in other areas of income allocation, people will consider tradeoffs. By partially reconnecting the consumption/payment link, HSAs provide people with an incentive to be smarter and more cost-conscious healthcare consumers. In addition, this approach returns insurance to its original purpose, to manage risk of catastrophic medical expenses as opposed to being a form of "pre-payment" for routine medical services.

CON and the Impossibility of Central Planning

CON regulations are an attempt at complete central planning of investment in healthcare-related facilities. The underlying premise is twofold. First, that individuals and companies acting in a free market will misallocate healthcare resources. As stated directly in Alabama's CON law, "... will be administered in the state to assure that only those healthcare services and facilities found to be in the public interest shall be offered or developed in the state."[24]

The second premise behind the law, implied by all that the law empowers the state to do, is that the state, through centralized bureaucratic allocation of healthcare investment, can improve on market results, and better serve the public's healthcare needs. The point here is that even if the first premise, as tenuous as it is, is accepted, there is no

reason to assume that a large scale intervention, such as authorized by CON laws, can do anything to improve the situation.

This second assumption ignores all that the economics profession has learned over the last 50 years regarding command-and-control methods of resource allocation and the central planning of both economies in general and specific markets within economic systems. All of the reasons economists typically give regarding why economic central planning fails, apply to CON regulations.

In a free market, resource allocation is driven by entrepreneurs who try to predict what consumer demand is and will be for the future. Before a physicians group invests in MRI equipment, for example, they would want to be sure the community of patients they serve would bring forth enough business to eventually make that investment pay off. They have powerful market incentives to get it right. If their market analysis is wrong, they lose money and their entire practice suffers. In other words, the best judges as to whether the service will be "needed" are the entrepreneurs and investors themselves. It is the profit and loss system that works to efficiently allocate investment and to provide the information necessary for making wise investments. In the absence of CON, these medical entrepreneurs would be operating in all aspects of the healthcare market. Hospitals will continuously re-evaluate their circumstances to determine if new birthing rooms are needed, or an expanded emergency room is necessary, or if a new helicopter evacuation unit would be worthwhile. The key is that in each of these cases they have a strong incentive to accurately assess the market and the community's "needs." If they can't, they lose money and must divert revenues and resources from other parts of their operations.

On the other hand, CON laws substitute bureaucratic decision-making for the market's entrepreneurial assessments. Government decision-makers have no basis for gathering accurate market information and, furthermore, they have no incentive to make investments in the right places, at the right times, and in the right amounts. Unlike the case with private entrepreneurs, if their decisions prove to be wrong, there are no personal consequences borne by the planners. In fact, there is no real way of determining subsequently whether or not a proper decision has been made. Conversely, a good entrepreneurial decision is one that accurately assesses healthcare consumers' needs and survives the competitive pressures of the marketplace. That is, it is a decision that satisfies consumer needs at least as well as, if not better than, existing and potential competitors.

For those who are granted membership in the CON-sponsored cartel, the real tests of the marketplace are forgone. In other words, the market forces that would ultimately determine whether a particular investment by a hospital, clinic, physician's practice, etc. truly served the needs of the community are blocked. Bureaucrats who judge CON submissions do not, indeed cannot, actually determine whether there is a need that will best be filled by a particular applicant, because they are outside the market process generating the information.

In his Nobel Laureate lecture, "The Pretense of Knowledge," economist Friedrich Hayek argued that central planners, like those charged with determining who should and should not provide medical services can only "pretend" to have the information necessary to make the kinds of decisions they make.

At best, any determination of "need" by such planners will be arbitrary and will not reflect actual market conditions. At worst, these planners can become witting or unwitting tools of entrenched interests wh wish to keep competition out of the market. As University of Pennsylvania analyst Mark Pauly noted, CON programs "tended to be 'captured' or dominated by the hospitals they were intended to regulate, and those hospitals used regulation to keep out competition."[25]

Conclusion

The Federal Trade Commission advises that "states with CON programs should reconsider whether these programs best serve their citizens' healthcare needs." In fact, Certificate of Need Laws in Alabama and other states should be explicitly repealed. State governments should not be aiding and abetting monopolies or their formation, or acting as a cartel enforcement mechanism for established healthcare interests. This is especially true in healthcare markets where competition, which is widely recognized by economists as the most effective tool for driving costs down, is sorely needed. Competition provides the incentives to discover new technologies and new efficiencies for delivering those technologies to patients.

The idea that in the area of healthcare services, free market competition can't work as a means of cost control is not grounded in either economic theory or empirical evidence. Indeed in areas where competition is allowed to flourish, such as optometry, the customer is well served with plenty of options and competitive pricing. Furthermore, believing that CON laws and the bureaucrats who administer them can do a better job

than the competitive market process is not only wishful thinking, it is the economic equivalent to believing the earth is flat.

Healthcare provision around the world is controlled by varying degrees of government central planning. Consequently, all systems tend to be dominated by different forms of healthcare market malfunctions. In countries like Canada and Great Britain, there are long queues and bottlenecks for vital services and treatments. In the United States, there are problems associated with high costs and affordability. None of these countries allow free markets and open competition. Government command-and-control has failed; it is time to let the free market work.

Endnotes:

[1] American Hospital Association, *AHA Hospital Statistics* (Chicago: Health Forum, LLC, 2006). page 11.

[2] John Bian and Michael A. Morrisey, "Free-Standing Ambulatory Surgery Centers and Hospital Surgery Volume," *Inquiry* 44(2):200-210 (Summer 2007).

[3] See Michael A. Morrisey, "Certificate of Need: Protecting Providers, Not Controlling Costs," in Allison Lake, ed., *Healthcare in Maryland: A Diagnosis* pp: 67-78 (Germantown, MD: Maryland Public Policy Institute, April 2005) and Health First, "More Good News for Viera Hospital!" http://www/vierahospitalnow.com (last accessed July 26, 2007).

[4] Dana Heupel, "GOP Senators Challenge Health Facilities Planning Board," *State Journal-Constitution* (December 26, 2006) http://www.senategop.state.il.us/index.php?option=com_content&task=view&id=296&Itemid=123 (last accessed July 26, 2007).

[5] Alabama Code 1975 Vol. 14A Section 22-21-266

[6] Christopher J. Conover and Frank Sloan, "Does Removing Certificate of Need Regulations Lead to a Surge in Healthcare Spending?" *Journal of Health Politics Policy and Law*, Vol. 23, No 3, June 1998.

[7] Charles Gerena, "Putting on the Brakes," *Region Focus*, Spring 2004, Federal Reserve Bank of Richmond. www.rich.frb.org/publs/regionfocus/spring04/brakes.html

[8] Ellen S. Campbell and Gary Fournier, "Certificate-of-Need Deregulation and Indigent Hospital Care," *The Journal of Health, Politics, Policy and the Law*, Vol. 18, No. 4, 1993, p. 906.

[9] Ellen Jane Schneither, et al. "Rising Healthcare Costs: State Health cost Containment Approaches," National Academy for State Health Policy, June 2002, p. 4

[10] See "The Federal Trade Commission and Certificate of Need Regulations: An AHP Critique, January 2005, http://www.ahpanet.org/con_issues.html and *Improving Healthcare: A Dose of Competition*, a report by the Federal Trade Commission and the Department of Justice, 2004, www.ftc.gov. It should be pointed out that among economists "Marxist" and socialist economics is considered to be the most prominent of the non-orthodox or "heterodox" approaches to economic analysis. It will be argued below that CON are indeed grounded in fundamental principles of what is called "market socialism."

[11] Article 9, Certificate of Need, p.1. As will be discussed at length below, healthcare services are over-utilized, not as a result of "the open market" but as interventions that distort the market.

[12] In the section below titled "The Impossibility of Central Planning" this will be referred to as "a pretense of knowledge" which is a term coined by Nobel Prize winning economist Friedrich Hayek

[13] Thomas R. Tingle, "Madison Hospital Decision Looming," *Huntsville Times* (August 29, 2007) www.al.com/news/huntsvilletimes/index.ssf?/base/news/1188378972106080.xml&coll=1

[11] Op. cit. at note 6.

[15] Joyce A. Lanning, Michael Morrisey and Robert Ohsfeldt, "Endogenous Hospital Regulation and its Effects on Hospital and Non-Hospital Expenditures," *Journal of Regulatory Economics*, Vol. 3, No. 2, 1991 as cited in *Ibid.*

[16] *Improving Healthcare: A Dose of Competition,* a report by the Federal Trade Commissions and the Department of Justice, July, 2004, *http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf*

[17] From FTC press release found at http://www.ftc.gov/opa/predawn/F89/nc-con.txt.

[18] Patrick John McGinley, "Beyond Healthcare Reform: Reconsidering Certificate of Need Laws in a Managed Competition System," *Florida State University Law Review*, Vol. 23, No. 1, 1995.

[19] Campbell ES, Fournier GM, "Certificate-of-need Deregulation and Indigent Hospital Care," *The Journal of Health, Politics, Policy and the Law*, Vol. 18, No. 4, 1993. Abstract found at http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=8120351&dopt=Abstract

[20] See http://www.census.gov/prod/2004pubs/04statab/health.pdf, table no. 120. "Personal Healthcare Expenditures by Object and Source of Payment: 2002"

[21] Ibid.

[22] This policy was implemented during WWII in order to get around strict controls on money wages. Tax-free benefits were then used as a way of attracting better employees.

[23] See Michael A. Morrisey, "Competition in Hospital and Health Insurance Markets: A Review and Research Agenda," *Health Services Research* 36 (1, part 2):191-221 (April 2001).

[24] Alabama Code 1975 Vol. 14A, Section 22-21-261

[25] As quoted by Terree Wasley, "Certificate of Need: Poor Healthcare Policy," Mackinac Center for Public Policy, June 17, 1993

[redacted]

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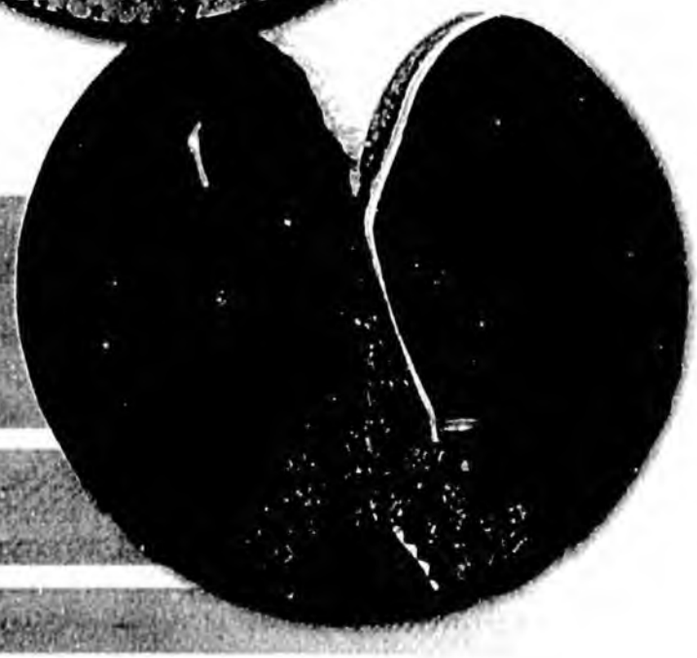
ASHNHA

Alaska State Hospital and Nursing Home Association

2008 Alaska Hospital Community Benefits Report

Alaska's Hospitals Creating Healthier Communities



Alaska's Hospitals:
Improving Health through Community Benefits

About this Report

The challenges to improving the health of Alaskans are as tall as our mountains and as unique as our topography, climates and communities. Each and every day, Alaska hospitals voluntarily offer programs and services in their communities that exceed traditional daily medical care. These programs and services — called Community Benefits — deliver health care assistance and solutions to specific populations with unique medical needs. The goal of Community Benefits is to improve the health of Alaska by improving the quality of life for Alaskans.

The Alaska State Hospital and Nursing Home Association (ASHNHA) is proud to present the *2008 Alaska Hospital Community Benefits Report.* While many people are familiar with hospitals' role as major employers, this is the first time ASHNHA has quantified and reported to Alaskans the Community Benefits provided by the state's acute care hospitals.

Community Benefits are programs and services that exceed the routine and emergency care provided around the clock daily by Alaska hospitals. Community Benefits are often provided free of charge or at substantially reduced fees. They are targeted programs and services that address the identified and often unique health care, social and welfare needs of the people who live in a particular community. These benefits provide measurable improvements in health status and access to health care for a community's residents. They also provide care to Alaskans regardless of ability to pay.

Sixteen Alaskan hospitals provided data to the *2008 Alaska Hospital Community Benefits Report.* Participating hospitals are Alaska Regional Hospital, Anchorage; Bartlett Regional Hospital, Juneau; Central Peninsula Hospital, Soldotna; Cordova Community Medical Center, Cordova; Fairbanks Memorial Hospital, Fairbanks; Ketchikan General Hospital, Ketchikan; Mat-Su Regional Medical Center, Palmer; North Star Behavioral Health, Anchorage; Petersburg Medical Center, Petersburg; Sitka Community Hospital, Sitka; South Peninsula Hospital, Homer; Wrangell Medical Center, Wrangell; Providence Alaska Medical Center, Anchorage; Providence Kodiak Island Medical Center, Kodiak; Providence Seward Medical & Care Center, Seward; and Providence Valdez Medical Center, Valdez.

Community Benefits: Saving & Changing Lives

Safe Kids Water Safety Program Saves Lives

Dan Baeten credits his 14-year-old son for saving the lives of his family members after attending the Safe Kids Water Safety community benefit event in Soldotna. The young man's personal flotation device and his knowledge of how to handle a boating accident saved the family when their canoes overturned and were swept down river on a treacherous stretch of water.

WOW Ride Gives Back

Oncology nurse Kathy Lopeman started a fun-filled winter snowmobile fundraiser. The event raised $34,000 to distribute to community members as $1,000 grants for those needing items not covered by insurance or assistance to travel for medical care.

FINDINGS:

ALASKA HOSPITALS PROVIDE $151.6 MILLION IN COMMUNITY BENEFITS

Alaska hospitals provided $151.6 million in Community Benefits to communities and citizens in 2006, the most recent year for which data are available. The hospitals also paid more than $10.3 million in taxes and fees to state and local governments. The data come from surveys completed in January 2008 by 16 Alaska hospitals (see complete list on page 2 under "About this Report.") Community Benefits are programs and services offered by hospitals beyond required daily health care services. They target specific populations in a community with assistance and solutions to unique health care needs.

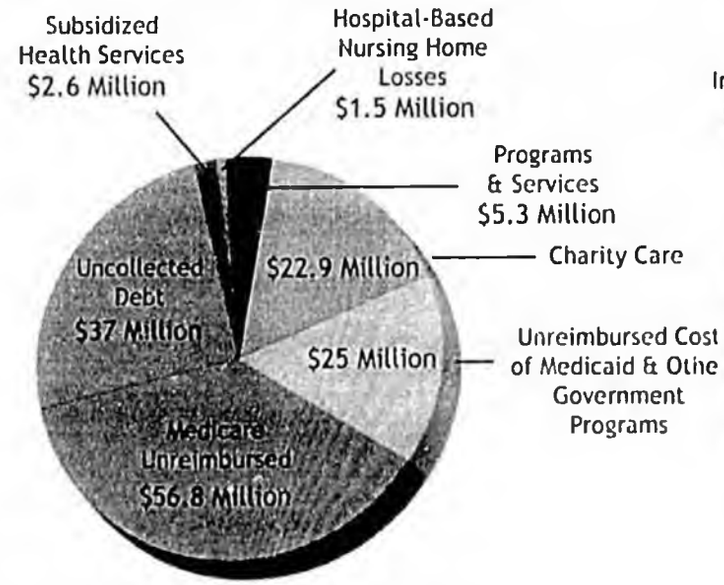
ASHNHA Community Benefits Survey Report Summary

Benefit Category	*Participants Served*	*Loss/Cost*
Community Health Improvement Services		
Community Health Education	57,394	$1,340,996
Support Groups	128	$2,798
Self Help	242	$1,900
Nonbilled/Reduced-Fee Clinics	7,016	$142,434
Health Screening	989	$49,494
Immunization	800	$18,807
Counseling	424	$76,755
Family Support Services	15	$2,120
Free/Discounted Prescriptions/Supplies to Patients	473	$75,51[illegible]
In-Home [illegible]ervices	307	$1,06[illegible]
Meals/Nutrition Services	5,382	$21[illegible],469
Transportation Services	628	$38,314
All Other Health Care Support Services	75	$500
Community Health Improvement Services Total	73,873	$1,963,159
Financial and In-Kind Contributions	15,730	$1,214,786
Health Professions Education Contribution	1,247	$2,044,967
Health Research Contribution	0	0
Community Building Activities	16,046	$79,375
Community Benefit Operations	0	$3,700
TOTAL PARTICIPANTS IN COMMUNITY BENEFITS PROGRAMS		106,896
Charity Care At Cost		$22,967,322
Medicaid Underpayment		$12,545,792
Losses on Other Public Programs (Excludes Medicare and Medicaid)		$12,543,156
Bad Debt at Cost		$37,198,890
Medicare Unreimbursed		$56,830,190
Subsidized Health Services		$2,664,408
Hospital-Based Nursing Home Losses		$1,501,816
TOTAL COMMUNITY BENEFITS		$151,557,561

Community Benefits Improve the Health of Thousands of Alaskans

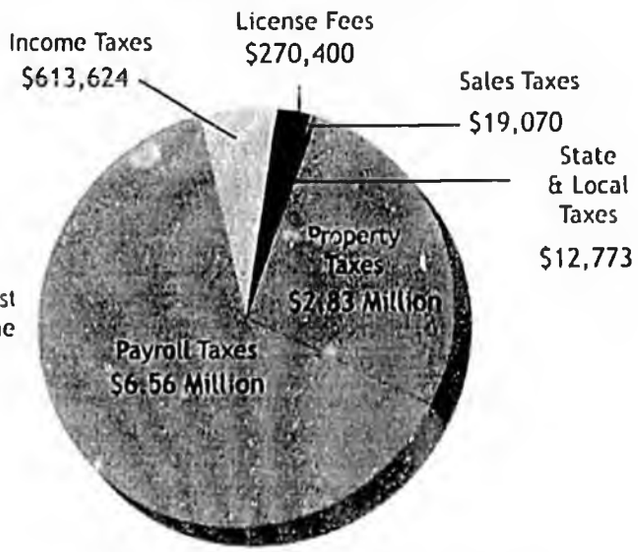
This report uses numbers to present the Community Benefits provided by Alaska hospitals. But Community Benefits are really about people. Community Benefits include care provided free of charge to Alaskans who are unable to pay. Programs and services can include prenatal care for expectant mothers and families, smoking cessation, preventing sports and other avoidable injuries, CPR and first aid classes, AIDS education and awareness, school-based health services, help for elderly citizens, work-site based health promotion, fitness and exercise seminars, blood pressure screenings, cholesterol testing, mental health and depression screenings, diabetes counseling, adult and child immunizations, blood drives, nutrition and weight loss management, substance abuse counseling, prescription drugs, transportation services, child car safety seat classes, and so much more. The goal of Community Benefits is to improve the health of Alaska by improving the quality of life for Alaskans.

Alaska Hospitals Provide $151.6 Million in Community Benefits



Total Value of Benefits Provided to Alaskan Communities: $151.55 Million

Alaska Hospitals Send $10.3 Million in Taxes, Fees to State and Local Governments



Total Payments to State and Local Governments: $10.31 Million

ASHNHA

The Federal Trade Commission
&
Certificate of Need Regulation

An AHPA Critique

January 2005

American Health Planning Association

. . . putting it all together

Table of Contents

I. Overview

In July 2004, the Federal Trade Commission (FTC) and the Department of Justice (DOJ) issued a joint report titled *Improving Health Care: A Dose of Competition.* Described as advisory in nature, ostensibly, it offers recommendations on how to "improve the balance between competition and regulation in health care."[1] The authors say they want "to inform consumers, businesses, *[and]* policy-makers on a range of issues affecting the cost, quality, and accessibility of health care."[2] Except for more effective enforcement of antitrust laws, which falls within the scope of the agencies' responsibilities, the report seeks to effect change by influencing the views and conduct of others, particularly national and State policymakers.

Eliminating certificate of need (CON) regulation is only one of several problematic arguments and recommendations presented. It is the only recommendation that has gained much public attention, but the issue is given only cursory, dismissive consideration in the report.[3] The overall thrust of the report is to encourage movement to a "consumer driven" health care system that relies on market forces to determine costs (prices), access, and quality. CON regulation and planning is seen as an obvious obstacle to this goal, but the report also cautions against:

- Over-reliance on health insurance;
- The system-distorting effects of Medicare and other "administered pricing" schemes;
- Economic cross-subsidies within the system;
- Government-imposed service mandates;
- Attempting to control prescription drug prices;
- Permitting collective bargains by physicians, and generally; and
- Any other action or process contemplated, in the pursuit of other (perhaps larger) social goals and interests that might limit competition or the full application of market forces.

Criticism of CON regulation in *Improving Health Care* is not surprising. Given the FTC *raison d'etre* of promoting free markets and unfettered competition, and its longstanding opposition to CON programs, little else could be expected. Nevertheless, the unsupported conclusion that CON programs "pose anticompetitive risks" and "risk entrenching oligopolists and eroding consumer welfare" is little more than doctrinaire posturing. Similarly, the recommendation that States with CON programs "reconsider whether these programs best serve their citizens' health care needs" is gratuitous. State legislatures do this regularly, often annually.

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[1] FTC-DOJ press release July 23, 2004, at <http://www.ftc.gov/opa/2004/07/healthcarerpt.htm>.

[2] *Ibid.*

[3] CON and related planning are treated briefly as "miscellaneous subjects" in Chapter 8, the last chapter of the report. Although there are occasional allusions to CON regulation elsewhere in the report, the question is discussed directly in fewer than 10 pages of the 350 plus page report. The cursory treatment of CON planning and regulation appears calculated: CON regulation is treated dismissively, almost as an afterthought, in the body of the report, but is elevated to prominence in the recommendations (number 2) offered "to improve competition in health care markets". ***Improving Health Care: A Dose of Competition.*** A Report by the Federal Trade Commission and the Department of Justice, July 2004. The full report is available at www.ftc.gov. See specifically Chapter 8 (pp. 1-6) and the Executive Summary (p.22), both of which discuss CON regulation directly.

II. Context & History

Improving Health Care is but the most recent, and perhaps the most visible, example of the decades-long FTC effort to shape the climate of opinion on health care.[4] In a February 9, 1987, letter to the Health Systems Agency of New York City, advising the agency to not try to reduce excess hospital bed capacity in the city, Jeffrey Zuckerman, Director of the FTC's Bureau of Competition, noted that the FTC had "been engaged in extensive efforts to preserve and promote competition in health care markets" for more than a decade.[5] A year earlier, Terry Calvani, FTC Acting Chairman, had made it clear that CON was a part of that effort:

> "A major initiative for the coming year . . . will be a program to halt actions by health-care providers which are designed to raise the costs and deter the entry of competitors. For example, state law frequently requires a hospital to obtain a "certificate of need" (CON) before it can build a new facility. The Commission has discovered that existing hospitals have sometimes opposed these CON applications, not in good faith, but merely to delay the entry of a new competitor and to burden it with heavy costs. The Commission will watch for such activities and will challenge them as trade restraints where appropriate."[6]

In other words, certificate of need (CON) regulation has long been anathema to the FTC. The Commission has actively opposed CON programs for at least the last two decades.

It is unclear how the FTC ascertained the motivation and intent of hospitals participating in CON review processes, but its attack on CON has not been limited to, or even meaningfully related to, preventing existing service providers from engaging in restraint of trade. Beginning in the mid-1980s, Commission staff regularly urged State policymakers and health care officials to eliminate or, alternatively, limit CON regulation. The period between 1986 and 1989 was particularly intense. Beyond its sustained generic opposition, during this period alone the FTC formally

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[4] Apparently, the Commission had no great concern about the structure and nature of the health care system before the advent the Medicare program and the economic and system changes dating from that period. There is little, if any, evidence of FTC concern about the structure and operational aspects of the health care system as long as its was dominated by market forces, i.e., before Medicare and other government-sponsored health and health-related programs.

[5] Jeffrey Zuckerman, Director, Bureau of Competition, U.S. Federal Trade Commission, to Giri Vuppala, Assistant Director, Planning and Implementation, Health Systems Agency of New York City, February 9, 1987, p. 2.

[6] See FTC press release, February 21, 1986 at www.ftc.gov. See also FTC annual reports for 1986 and 1987, U.S. Federal Trade Commission, Washington, D.C.

opposed CON regulation in Georgia[7], Hawaii[8], Maryland[9], Michigan[10], Nebraska[11], New York[12], North Carolina[13], Ohio[14], Pennsylvania[15], and Virginia.[16]

FTC attacks have been multifaceted, with arguments ranging from the purported failure of CON regulation to meet legislative cost control objectives to assertions that it results in higher operating costs and charges, threatens quality, reduces innovation and system efficiency, and

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[7] In March 1988, FTC staff said "We believe the continued existence of CON regulation is contrary to the interests of health care consumers in Georgia. . . . More importantly, CON regulation tends to foster higher prices, lower quality and reduced innovation in health care markets". See FTC press release, March 7, 1988, at www.ftc.gov.

[8] In early1987, FTC staff told Hawaii legislators "we strongly encourage repeal of CON legislation. There is no evidence that the CON regulatory process has served its intended purpose of controlling health care costs. Indeed, CON regulation may well increase prices to consumers by restricting supply of hospital services below the level that would exist in a non regulated competitive environment." See FTC press release, March 17, 1987, at www.ftc.gov.

[9] In 1987, FTC staff advised Maryland policymakers to not control ambulatory surgery center development under the State's CON program. See FTC Annual Report, 1987, U. S. Federal Trade Commission, Washington, D.C. at www.ftc.gov.

[10] In March 1988, FTC staff advised Michigan health officials that the State's CON regulations were (are) "contrary to the interests of health care consumers in Michigan" because they "tend to decrease efficiency and impede competition." The staff also asserted "any potential benefits of CON regulation are likely to be outweighed by its adverse effects on competition in health care markets." See FTC press release, May 9, 1988, at www.ftc.gov.

[11] In February 1989, FTC staff informed the Nebraska Legislature "continuing CON regulation is likely to harm consumers by increasing the price and decreasing the quality of health services." See FTC press release, February 24, 1989, at www.ftc.gov

[12] In February 1987, FTC staff advised New York City Health Systems Agency officials that a contemplated reduction in excess hospital capacity "would substantially reduce the incentives for hospitals in New York City to improve the price and quality of their services." Consequently, officials should "rely on the hospitals themselves, rather than government regulation, to determine appropriate capacity levels." See FTC press release, February 10, 1987, at www.ftc.gov.

[13] In March 1989, FTC staff told the North Carolina policy-makers "CON regulation does not appear to be an efficient way to ensure the quality of health care services, to assure that health care is available to the indigent, or to control Medicaid expenditures for nursing home beds." Staff also argued "consumers would most likely be better served if CON regulations were removed." See FTC press release, March 14, 1989, at www.ftc.gov.

[14] In June 1989, FTC staff told the Ohio State Senate "'there is near universal agreement' among health care economists that Certificate of Need regulation 'has been unsuccessful in containing health care costs.'" See FTC press release June 22, 1989, at www.ftc.gov.

[15] In April 1988, FTC staff urged Pennsylvania to eliminate CON regulation, arguing "the benefits of CON regulation, if any, are likely to be outweighed by the adverse effects of such regulation on competition in health care markets. Consequently, continuing CON regulation is likely to harm consumers by increasing the price and decreasing the quality of health services in the state." See FTC press release, April 1, 1988, at www.ftc.gov

[16] In August 1987, FTC staff advised Virginia officials to eliminate its CON regulation of health care facilities because such regulation is "contrary to the interests of health care consumers" and "market forces generally allocate society's resources far better than decisions of government planners." FTC staff also asserted "any potential benefits of CON regulation are likely to be outweighed by the adverse effects of such regulation on competition in health care markets. Consequently, CON regulation is likely to harm consumers on balance by increasing the price, and decreasing the quality, of health services in Virginia." See FTC press release, August 10, 1987, at www.ftc.gov.

limits access to care. Whatever the focus of the argument presented in individual states, the underlying FTC argument in all cases was, and remains, that in health care—as in other sectors of the economy—an unregulated market is superior to planning and regulation in assuring quality, access and cost-effectiveness. In addition to consistently opposing CON regulation for at least the last 20 years, the FTC has also opposed related state planning and regulatory initiatives.[17]

Fourteen states have dropped their CON programs since the mid-1980s. It is not clear how many of these states, if any, responded to FTC arguments or recommendations. Commission staff was active in a number of them, responding to the inquiries of CON opponents, advising state lawmakers to oppose or otherwise limit CON regulation, and preaching the redeeming value of market forces in health care. FTC officials have devoted substantial effort to opposing CON regulation and appear to believe their campaign was necessary, if not uniformly successful. After a brief hiatus, they now appear ready to resume the crusade.

Ostensibly, *Improving Health Care* was issued as an "educational resource" to States and other interested parties. It is unclear how State policymakers will respond to the current FTC advice. Those engaged in the day-to-day struggle to make health care available and affordable, or at least nominally accessible, to all in need necessarily have proven resistant to the siren song of free markets and unfettered competition as *the* solution to cost, quality and access problems. Nevertheless, the 2004 report will certainly encourage opponents of CON, whatever their motivation.[18] There is likely to be much discussion in State legislatures during upcoming legislative sessions. CON regulation is likely to remain in the FTC crosshairs as long as a significant number of States have such programs.

III. Nature of the FTC Critique

Stated simply, the FTC argument against CON regulation holds that health care is as much subject to orthodox economic principles and doctrine as any other sector of the economy. Consequently, the best (i.e., the surest, most effective, most efficient) way to assure quality, efficiency, access, innovation, and lower prices is to rely on market forces and competition. The Commission recognizes that many do not view health care as a commodity that is, or should be, responsive to market forces. The authors lament that much of the public, nationally and internationally, view health care as "a special good" that is "not subject to normal market forces, with significant obligational norms to provide necessary care without regard to ability to pay."

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[17] The FTC opposed the enactment of "certificate of public advantage" legislation in a number of states in the 1990s. These legislative initiatives attempted to provide guidance and "safe harbors" for certain cooperative arrangements that appeared warranted, especially following the sharp nationwide reduction in inpatient hospital use during the previous decade, to promote efficiency and the financial viability of some services. On March 10, 1993, FTC staff advised North Dakota officials that such legislation "could raise costs and reduce quality". See FTC press release, March 10, 1993 at www.ftc.gov. Similar advice was presented to Vermont officials on October 20, 1994. See FTC press release, October 20, 1994 at www.ftc.gov

[18] See, for example, the Virginia Department of Planning and Budget's *Economic Impact Analysis* of proposed revisions to Virginia's Certificate of Public Need State Medical Facilities Plan. The "analysis" is a gratuitous attack on certificate of need regulation, clearly modeled after the FTC argument and assumptions. Copies of the Virginia report are available from the Health Systems Agency of Northern Virginia, Falls Church, VA.

An underlying objective of the report is to change views on this question, especially among policymakers. The authors' recognize that mediating forces (insurance, public health and payer programs, lack of accurate and reliable cost and quality information, and the absence of a truly independent and sovereign consumer) make the current health care market an imperfect one. They insist that, given this circumstance, all efforts should be directed at perfecting the market, and paying directly any additional cost that a free unfettered market may entail.

FTC arguments presented in opposition to CON regulation, and in support of unrestrained market forces, are necessarily largely doctrinaire. There is little analytical or factual basis for the criticism of CON or for the recommendation to eliminate it. Similarly, other than recitation of orthodox economic doctrine, little is presented to demonstrate that market forces have had, or are likely to have, the positive effects in the health care system that the authors claim or assume.

The FTC opposes most barriers to market entry, whatever their nature, purpose or function, as an article of faith. The report makes clear that the FTC opposition is grounded in orthodox economic doctrine and the principles of the "American" market system. The Executive Summary of the report concludes with the report anthem:

> "The fundamental premise of the American free-market system is that consumer welfare is maximized by open competition and consumer sovereignty – even when complex products and services such as health care are involved. . . . The Agencies do not have a pre-existing preference for any particular model for the financing and delivery of health care. Such matters are best left to the impersonal workings of the marketplace." ***Improving Health Care: A Dose of Competition, Executive Summary***, p. 11.

In other words, the FTC is not in favor of a particular model as long as the *de facto* model is the "American free market" model. Doctrine, or perhaps faith and hope, trump experience and reason. This is not surprising, given the FTC's mission of promoting competition. This inherent bias, though understandable, does not absolve the Commission of its responsibility to avoid substituting belief for fact, or to refrain from accepting uncorroborated allegations of interested parties as fact. The report, and the record compiled in producing it, shows the Commission relied on belief and uncorroborated allegations rather than demonstrated fact in its rebuke of CON.

Although packaged and presented as a major new report, the evidence and argument against CON regulation is either a rehash of FTC arguments from the 1980s,[19] or the uncorroborated self-serving allegations of interested parties.[20] There is a notable absence of documented fact or cogent analysis. No new evidence is offered to support the claim that, by raising market entry barriers for some services, CON raises costs, impedes access, or threatens quality. References to

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[19] See Keith B. Anderson and David I. Kass, ***Certificate of Need Regulation of Entry into Home Health Care***, FTC staff report, January 1986; Monica Noether, ***Competition Among Hospitals***, FTC staff report, May 1987; and Daniel Sherman, ***The Effect of State Certificate-of-Need Laws on Hospital Costs: An Economic Policy Analysis***, FTC staff report, January 1988.

[20] See unsupported and anecdotal testimony of John Hennessy, Executive Director, Kansas City Cancer Centers (a subsidiary of U. S. Oncology) and Megan Price, Director, Contracts and Communications, Professional Nurses Association. Both were (are) disappointed CON applicants who made bold, uncorroborated assertions that are problematic on their face.

recent empirical evidence of the value of regional planning and CON regulation in helping control costs and maintaining quality are dismissed by citing the anecdotal comments of CON opponents.[21]

To the extent the FTC argument against CON is grounded in analysis, it is based largely on three FTC staff reports produced in the mid-1980s. These are unusually weak studies. All three are macro econometric studies that involve multivariate regression analysis of aggregated data obtained from standard sources, e.g., state licensure programs, American Hospital Association surveys, and Medicare data. All are burdened by the inherent weaknesses of such examinations of the health care system. Concerns include whether the factors being examined are actually being measured, whether the data used are accurate, reliable, or relevant, and whether the methods used are actually applicable to the question raised. For example, though undertaken in the mid-1980s, the health service and cost data examined in the three FTC staff reports comes from 1977-78 (Noether, Hospital Competition), 1981 (Anderson, Home Health Care Costs), and 1983-84 (Sherman, Hospital Costs).

Underlying assumptions that planning and CON regulation of certain capital costs had (or could have) readily discernible effects in such a short period (PL 93-641 was enacted in 1974 and implemented in 1976) are problematic, attempts to account analytically for these deficiencies notwithstanding. The accuracy and reliability of the data used in these studies are equally questionable. If ever of any value, all three have been eclipsed by changes over the last two decades and have lost any relevance they may have had. Repeated citation by the FTC does not improve or add to the credibility of these studies, or of similar reports that have been cited repeatedly but conflict with experience.

Virtually all of the arguments against CON made by the FTC to State policymakers have been conjecture, based on theory and doctrine rather than acknowledged fact or demonstrated cause and effect. There are few reliable studies of the effects, if any, on the costs and charges for services subject to CON regulation. The results of studies that have been performed have been mixed. In the 1980s, when the FTC staff made representations about the negative effects of CON regulation on access, quality, innovation, and system efficiency, there were few, if any, studies or data that supported these arguments. They were assertions derived from an abiding faith in the effectiveness and unalloyed good of market forces.

Even today there are few studies that try to assess objectively the effects of CON regulation on regulated services. Whatever the purported results, all are regression and correlation studies that do not demonstrate or explain cause and effect. Recent studies that try to discern quality effects of CON regulation generally favor CON regulation.[22] Notwithstanding the repeated claims of FTC staff, there are still no reliable studies that show negative access, innovation, or system efficiency

[21] Recent favorable reports of lower automaker health care costs in states with CON programs, and reports of lower open-heart surgery mortality rates in states with CON programs, are dismissed in this fashion.

[22] See, for example, General Motors Corporation. Statement of General Motors Corporation on the Certificate of Need (CON) Program in Michigan, February 12, 2002; Ford Motor Company. Relative Cost Data vs Certificate of Need (CON) for States in Which Ford has a Major Presence, February, 2002; DaimlerChrysler Corporation. Certificate of Need: Endorsement by DaimlerChrysler Corporation, February 2002. Vaughan-Sarrazin, MS, Hannan, EL, Gormley, CJ, Rosenthal, GE. "Mortality in Medicare Beneficiaries Following Coronary Artery Bypass Graft Surgery in States With and Without Certificate of Need Regulation," JAMA, Vol. 288 No. 15, October 16, 2002, 1859-1866.

effects of CON regulation. Statements to the contrary notwithstanding, these are doctrinaire assertions, not demonstrated fact.

IV. Allusive Arguments

The FTC assertion that, rather than helping control costs, "there is considerable evidence" that CON "can actually drive up prices by fostering anticompetitive barrier to entry" is not supported by credible evidence. This uncorroborated assertion is typical of the argument presented. No source for this conclusion is cited. The language, like the argument itself, is in the subjunctive, opaque and indirect. Considerable evidence is not otherwise defined or identified. So-called "anticompetitive barriers," such as CON, are not clearly distinguished from barriers such as licensure and insurance payment rules and regulations that, though they limit or otherwise affect market entry as forcefully as CON regulation, presumably do not rise to the level of being an "anticompetitive barrier".

The opaque assertion that CON "can actually drive up prices" permits the writers to project their views without having to meet the burden of proving them. Orthodox economic theory holds that market entry barriers "can," and often do result in higher prices in many markets, but there is no credible evidence that CON has, or necessarily does, lead to higher costs in health care. Recourse to theory is necessary if the argument is to appear plausible. In other words, if there is not evidence to document the practice or effect, simply assert repeatedly the belief or theory.

V. Related Opinions and Findings

The attack on CON, though sharp, is a small part of *Improving Health Care*. Perhaps more problematic are the related assumptions, beliefs and recommendations that, if implemented, would undermine community and regional planning, and subject those in need of health services to the vagaries of unfettered market forces. These views and assumptions include:

- *Opposition to Internal Subsidies (Cross-subsidies).* The report recommends that governments (federal and state) re-examine their support of policies and practices that underlie cross-subsidies in health care markets. The rationale offered for this recommendation is that internal (service-to-service) subsidies are inefficient and have the "potential to distort competition."

  The report is indifferent to the implications of the loss of service to those who now benefit from these subsidies, noting that "competition cannot provide resources to those who lack them; it does not work well when certain facilities are expected to use higher profits in certain areas to cross-subsidize uncompensated care." If there is a genuine commitment to assist those benefiting from cross-subsidization, the necessity of such assistance should be weighed and, if found meritorious, be provided directly to recipients (presumably through direct payment or vouchers) because that approach would be "more efficient" and "transparent". There is no discussion of the practicality of this approach or of the likely affects on current beneficiaries of subsidies. The net social and health system gain (benefit) of eliminating cross-subsidization is assumed to be positive.

- *Health Insurance Distorts Markets and Competition.* The report does not recommend specific changes in the Medicare program or in other health insurer coverage or payment practices, but asserts repeatedly that insurance coverage and payment

practices, particularly those of the Medicare program ("government administered pricing"), interfere with market forces and competition.[23]

The report cites approvingly the commentary of Newt Gingrich that "the third party payment model is inherently conflict ridden"[24] and that these insurance schemes "distort incentives and have unintended consequences". According to the report, these distortions explain the rise of ambulatory surgery centers and single-specialty hospitals, particularly cardiovascular services specialty hospitals. The import of the argument is that both Medicare and other third party payers are problematic because they shield individuals from the economic effects and implications of their health care choices and use. From the FTC perspective, if third party payment is to be permitted, high deductible and high co-payment coverage structures are desirable.

- *Government Purchasing of Services*. The report is highly skeptical of government purchasing of health care services on behalf of citizens, because it shields the recipient of such care from the disciplining effects of market forces. Hence, although neutrality is claimed on possible financing schemes, the authors warn against single-payer financing arrangements on the grounds that "government purchasing that reflects monopsony power would likely reduce output and innovation."[25] The report makes clear that this and related concerns apply to both the existing Medicare and Medicaid programs and to any expansion of them such as any effort (e.g., government purchasing or regulation) to control the costs of, or improve access to, prescription drugs.

- *Physician Self-Referral*. Although the FTC and DOJ are charged with preventing monopoly and rooting out restraint of trade practices, and oppose collective bargaining among independent physicians on these grounds, they show little concern about self-referral among physicians. They note approvingly that single-specialty hospitals (SSHs) established recently in states without CON programs "differ from their predecessors in that many of the physicians who refer patients have an ownership interest in the facility." Rather than question this arrangement, or examine carefully the significance of physician-driven decisions in health care and the underlying incentives and practices, the authors "encourage further research into the competitive significance of SSHs." The FTC is especially interested in determining "whether payors can discipline general acute care hospitals by shifting a larger percentage of patients to SSHs."[26]

- *Excess Capacity*. Stated simply, the "Roemer effect" is not recognized by the FTC. As indicated in its recommendation to the New York City Health Systems Agency, a market driven system does not have, or will not long have, excess capacity. According to market

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[23] "Any administered pricing system inevitably has difficulty in replicating the price that would prevail in a competitive market. Not surprisingly, one unintended consequence of the CMS administered pricing systems has been to make some hospital services extraordinarily lucrative and others unprofitable. As a result, some services are more available (and others less available) than they would be in a competitive market." ***Improving Health Care: A Dose of Competition, Executive Summary, p. 9.***

[24] "A large majority of consumers purchase health care through multiple agents. This multiplicity of agents is a major source of problems in the market for health care services. Agents often do not have adequate information about the preferences of those they represent or sufficient incentive to serve those interests." ***Improving Health Care: A Dose of Competition, Executive Summary***, p. 11.

[25] ***Improving Health Care: A Dose of Competition, Executive Summary***, p. 20.

[26] ***Improving Health Care: A Dose of Competition***, Chapter 3, p. 18.

theory, some level of surplus capacity—the level to be determined by market forces—is necessary for a competitive system. FTC staff assumes that the market will punish, and ultimately root out, surplus capacity, inappropriately low occupancy levels, and inefficiency (e.g., low throughput). In other words, there cannot be too many hospitals, hospital beds, or too much service capacity of any kind in a free market.[27]

VI. Supportable Report Findings and Recommendations

- *Information Asymmetry*. The report recognizes that a major imperfection in the current system is the lack of accurate and reliable cost and quality information consumers can use in seeking health services. The recommendation for a concerted, system-wide effort to make more of such information available is commendable. Unfortunately, the report does not recognize or acknowledge that knowledge and information asymmetry is inherent (unavoidable), nor does it suggest ways to deal with this question.

- *Enhance Incentives to Lower Costs and Improve Quality*. The recommendations offered in the report are generic in nature and unobjectionable. The need to improve incentives to reduce or control costs, and to improve quality is recognized and accepted by nearly everyone. Unfortunately, little guidance is offered about the specific questions to be addressed, the means to address them, or the problems likely to be encountered in dealing with them.

- *Implement Institute of Medicine Licensure Reforms.* The suggestion that the membership, and consumer representation on state health facility and service licensing boards be broadened is laudable. Both the scope and substance of licensing decisions, and the processes used in making them, need reform.

VII. Problematic Report Findings and Recommendations

- *Eliminate CON Regulation*. The recommendation that CON programs be eliminated is based largely on doctrine. The argument is a repackaged version of decades-old FTC arguments and positions. No new studies or analyses are offered. Empirical evidence and recent studies and experience showing the benefits of CON regulation are largely dismissed, not disproved.

- *Re-examine Subsidies in Health Care Services*. The value of all health care polices and practices should be examined periodically as a matter of course. In fact, most are. The underlying FTC argument against cross-subsidization is based on orthodox economic doctrine, not on an assessment of their intrinsic merit or the rationale for them. Most subsidies are in place for notably laudable purposes. Some, perhaps all, may need to be reconsidered, but not for theoretical or doctrinal reasons. The evolved connection between cross-subsidization, provision of charity care, and CON review contingencies and conditions is of considerable social value. Current practices should not be changed unless meaningful alternatives are in place.

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[27] Jeffrey Zuckerman, Director, Bureau of Competition, U. S. Federal Trade Commission, to Giri Vuppala, Assistant Director, Planning and Implementation, Health Systems Agency of New York City, February 9, 1987.

- *Prohibition of Physician Collective Bargaining*. Though a relatively small issue, the argument against collective bargaining among independent physicians is doctrinal in nature. The presumed negative effects of collective bargaining on quality and costs are theoretical. The FTC position appears to be more a statement of the Commission's social views, not one based on analysis or evidence.

- *Regulation of Pharmacy Benefits Manager Transparency*. The problems with prescription drug prices, and with obtaining reliable information about their efficacy and cost, are manifest. The FTC recommendation that there be no government regulation of pharmacy managers appears to be an attempt at preemption. The argument and recommendation are illustrative of the doctrinal nature of the FTC positions. The report acknowledges that accurate and reliable information is necessary, but rejects government action to ensure that such information is available to payers and consumers. It falls back on the doctrinal argument that a free market should be relied on to produce the information that is needed to discipline the system.

- *Service mandates*. As with cross-subsidization, the FTC argument against service mandates is based largely on orthodox economic theory, and hence doctrinal in nature. There is no meaningful analysis of the rationale for, the value of, or the costs of mandates compared with alternatives. The merits and costs of service coverage mandates should be reviewed periodically, but eliminating them in the name of economic orthodoxy is not warranted.

VIII. Arguments Against FTC Assertions and Assumptions

- *The health care market is inherently imperfect*. The FTC recognizes that the usual benefits of competition are not achievable in the health care system under current conditions. The report acknowledges a number of glaring market imperfections that need to be cured if market forces and competition are to have their presumed beneficial effects. The problems cited include the mediating influence of service selection and purchasing intermediaries such as insurance, Medicare, physicians and other health care professionals, the lack of price and quality information, legislatively imposed service mandates, cross-subsidization within the system, and service to all in urgent and emergent circumstances regardless of ability to pay.

  The report argues that these imperfections should be cured as quickly as possible. Whatever the merit of this view and argument, cures are not likely soon. Even if acted upon aggressively, the changes required would take years to accomplish in most cases. Community-based planning and CON regulation are linked to, and help compensate for, a number of these imperfections. It is important to maintain and strengthen planning and targeted CON regulation until the related market imperfections are corrected.

- *Health care is not, and should not be treated as, a commodity*. Although the FTC does not state directly that health care should be treated as an economic commodity, its arguments and assumptions make practical sense only if that were the case. Even in theory, much less in practice, market forces can have the system-shaping effects the FTC calls for, and argues will result from unfettered competition, only if health care is treated as any other economic good. The report laments that many, if not most, people see health care as "a special good" that is not, and should not be, subject to orthodox market forces. The

positive aspects of planning, CON regulation, facility licensure, and a number of other mediating social constraints are in place, in part, because market forces do not, and probably cannot, be used to discipline this market.

- *The studies critical of CON cited by the FTC are not reliable.* The argument that planning and CON regulation result in higher costs and prices, inferior quality, reduced access, less innovation, and lower operating efficiency, though asserted repeatedly, is not supported by demonstrated fact. This refrain is based largely on an unwavering adherence to orthodox economic doctrine.

  Most of the sources cited that purportedly show negative economic and quality effects of CON regulation, are FTC staff reports and FTC staff statements, which, in turn, are often based on these studies. Thus, many of the citations are self-referential. The base studies themselves are suspect. The data used, the timeframes covered, and analytical processes relied upon are problematic. The conclusions drawn are debatable. Based on multivariate regression analysis and statistical correlation, none of these "studies" demonstrates cause and effect and, beyond theoretical conjecture, none explains the method or mechanism by which the changes observed were achieved.

  Analyses that try to examine the economic and quality effects of CON regulation yield mixed findings, not the uniformly negative results asserted in the FTC report. Contrary to the impression conveyed in the FTC report, there are no reliable studies showing the effects of CON regulation on access to care, system efficiency, innovation, or other specific system characteristics.

- *Empirical evidence and experience are ignored or treated dismissively.* The recently reported experience of U.S. automakers showing lower costs in States with CON programs, and published analyses showing significantly lower mortality rates among open-heart surgery patients in States with CON programs, are dismissed. This information, when acknowledged, is usually cited in the testimony of a commentator or hearing panel member and dismissed by pairing it with opposing anecdotal testimony of CON critics.

- *Health care as a privilege.* The FTC prides itself on working in the interest of the consumer, the average citizen. It argues that "consumer driven" health care system is desirable and possible if market forces are permitted free reign. The paean to consumer control, though superficially attractive, borders on the disingenuous when examined in the light of economic and health system realities. The report prescribes theoretical cures to real problems. The discussion is at the macroeconomic level. The assumption appears to be that, if you address, at least theoretically, overarching system questions and imperfections, maximum benefit will flow (trickle down) to the individual.

  Unfortunately, the individual is treated as a theoretical economic entity or construct. Market realities are such that, under FTC prescriptions access, to quality health care would become a privilege, not a right or reasonable social expectation, dependent upon the economic standing, the knowledge base, and the social status of the individual. The report appears to anticipate and endorse this outcome. It speaks approvingly of consumers needing incentives to "balance costs and benefits and search for lower cost health care with the

level of quality that they prefer."[28] Presumably, the poor might "prefer" a "level of quality" consonant with what they could afford. As with any other commodity, an unfettered health care system will offer many different quality levels or categories, in both clinical and economic terms.

IX. Arguments in Favor of Planning and CON Regulation

- *CON is a useful market balancing tool*. In a necessarily imperfect, and an increasingly inequitable, health care system, community-based planning and CON regulation are flexible tools that, when used intelligently and objectively, help protect the critical health care infrastructure that is required to meet both expected and unanticipated public need. Market forces are invaluable in balancing the cost, supply, access, and quality of most goods and services. Market fluctuations and vagaries are acceptable for most commodities, but are problematic for essential social goods and services, especially health care.

- *Under current and expected health system market conditions, community-based planning and CON regulation are useful in promoting competition*. CON regulation, and related planning, can be and has been used to provide consumers and other purchasers with price and quality information. They also are used to stimulate direct competition and market entry where evidence indicates this would improve system operations and efficiency.

- *Recent empirical evidence shows substantial economic and service quality benefit from CON regulation and related planning*. Empirical studies by all three major U.S. automakers show substantially lower health care costs in states with CON programs.[29] Similarly, the most recent and largest study of CON regulation on treatment outcomes found that open heart surgery mortality rates are more than 20% lower in states with CON regulation than in states without regional planning and regulation.[30]

- *CON regulation is one of the few practical planning tools available to policymakers.* Whatever its limitations, CON regulation, with related community-based planning, is one of the few tools that policymakers, health system officials, and ordinary citizens have available for use in trying to compensate for known weaknesses and deficiencies in the existing health care system. CON decision-making processes provide a unique forum where all interested parties, and ordinary citizens, can express their views and state their needs. This oversight is distinct in that it often is the only light available to illuminate important quality, cost, and access concerns that are important to consumers.

- *CON regulation is the only practical tool available to implement basic planning policies and practices*. The relationship between average annual service volume and treatment

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[28] ***Improving Health Care: A Dose of Competition,*** *Executive Summary*, p. 5.

[29] General Motors Corporation. *Statement of General Motors Corporation on the Certificate of Need (CON) Program in Michigan,* February 12, 2002; Ford Motor Company. *Relative Cost Data vs Certificate of Need (CON) for States in Which Ford has a Major Presence*, February, 2002; DaimlerChrysler Corporation. *Certificate of Need Endorsement by DaimlerChrysler Corporation*, February 2002.

[30] Vaughan-Sarrazin, MS, Hannan, EL, Gormley, CJ, Rosenthal, GE. "Mortality in Medicare Beneficiaries Following Coronary Artery Bypass Graft Surgery in States With and Without Certificate of Need Regulation," *JAMA*, Vol. 288 No. 15, October 16, 2002, *1859-1866*

outcome is well known. It has been documented repeatedly for many of the services regulated under CON programs. CON regulation is the most reliable and practicable tool for implementing service, institutional and regional planning policies and practices that facilitate and ensure appropriately high program volumes.

X. Conclusions

Improving Health Care: A Dose of Competition appears to be largely a political treatise. It is not an analytical study. The underlying purpose appears to be an attempt to frame (shape) the debate over the nature and evolutionary direction of the U.S. health care system. It touts a "consumer driven" system as the ultimate goal. The report argues that this is possible if the nation has the courage to forgo internal subsidies, service mandates, over-reliance on insurance and government financing and purchasing, government regulation, and associated practices. Reliance on unrestrained market forces is prescribed as the best approach to determining health care capacity, cost, quality, and access. The negative effects of unfettered competition are not examined.

In terms of health planning and CON regulation, the report repackages and restates decades-old arguments against regulation. No new data, information or analysis is offered, and empirical evidence indicative of the efficacy of CON regulation and associated planning is dismissed. By almost any measure, the presentation is largely doctrinaire, based on an unwavering belief in the applicability of orthodox economic doctrine in health care rather than an objective analysis of market realities and experience.

The stated FTC goals of market efficiency, consumer control and informed stakeholders have been integral to community-based health planning for more than 40 years. The community has always been, and remains, an integral part of the planning, development and regulatory processes. The principal difference between FTC beliefs and assumptions, and those favoring planning and targeted regulation is how best to manage the tension between public and private interests, and between short-term and long-term perspectives and incentives. AHPA has always believed in the importance of community-oriented health care services and systems, and encourages ongoing reassessment of health planning and CON regulation to ensure they remain responsive to technological change, evolving health care practices, and community values and needs. The Association will continue to support these principles and practices.

ASHNHA
Alaska State Hospital and Nursing Home Association

REASONS FOR CONTINUING CERTIFICATE OF NEED IN ALASKA

- **Health care is not a conventional market; its economic forces are different.**
  - Health care has a finite need in each community. Introduction of additional medical providers redistributes finite revenue among more providers with 'winners and losers' in the community. Community hospitals will be the 'losers' as profitable services are aggressively sought by new imaging, surgery and specialty hospital providers. This will have profound adverse impact on their ability to fully meet community expectations.
  - Hospitals and nursing homes must offer a full range of outpatient inpatient and emergency services 24 hours a day, 7 days a week, 365 days a year. A number of these essential services do not produce adequate revenue to offset their cost of operation yet they must be offered to fully meet the needs of the community.
  - Health care is heavily regulated by federal & state laws. These regulations do not afford the health care provider the same flexibility and efficiency found in other markets. For example, a reduction in profitable service lines cannot be recovered by increased pricing as nearly one-half of hospital revenue comes from sources that set their own pricing (Medicare and Medicaid).
  - There is no assurance that introducing additional health care providers in a community will reduce cost to the consumer. In fact there is recent research that continues to suggest otherwise.
- **Hospitals must serve all persons in the community that need care regardless of ability to pay and are the key responder in community disaster response.**
  - Without CON, specialty providers can enter the market and create unfair competition by offering only the most profitable medical services and limiting the number of non-paying and underinsured patients that they will see.
  - 18 of Alaska's 25 hospitals are 'sole community providers' which risk financial instability and irreparable harm to community residents if the State does not insure that there is need for more health care infrastructure before it is introduced into the community.
  - Hospitals invest preparedness funds and extensive training to serve the community in event of natural disasters, pandemic flu, biological, and chemical threats. These expenses are not recovered from health care purchasers and only partially offset by federal/state grants. CON helps assure these important services will not be threatened by loss of critical revenue to keep these protections in place.

- **CON is an important health policy tool that balances community need with growth.**

  - There are many examples of health care projects initiated in communities around the country where "profit" motives take priority above overall "community good". The CON review process focuses on these issues and assures the project is in the best interest of patients as well as the community.

  - Without a strong CON process, over-building of health care services will occur in some areas, while critically needed medical services will not be developed in other areas. Developers will go into geographic areas where they see an opportunity, not into areas where they see marginal return on investment.

  - 36 states plus the District of Columbia continue to require CON approval for one or more categories of health services. Further, some states have gone beyond CON and put moratoriums in place to prohibit growth in certain medical services.

- **Current CON laws are not preventing needed growth in Alaska's health care infrastructure.**

  - Since reopening of the CON process in 2005, the Department of Health & Social Services has approved a number of new health care projects and has allowed others to proceed without CON review.

  - Alask 's hospitals and nursing homes are required to apply for CON approval before embarking on any new expansion project. Other parties interested in providing health care services should be exposed to the same rigorous review with the exception of 'physician offices' which are exempted from CON under current law.

- **Over building of medical infrastructure will worsen Alaska's workforce shortage.**

  - Alaska is already facing a critical shortage of physicians and nurses. This situation is not expected to improve in the short term. Many of the projects subject to CON review would require the most specialized professionals in radiology and surgery.

  - If we do not control the growth in Alaska's medical infrastructure we will see staffing shortages in our hospitals and nursing homes beyond anything we have experienced to date.

Health Program

Certificate of Need: State Health Laws and Programs

December 1, 2006 - preliminary edition

Certificate of Need (C.O.N.) programs are aimed at restraining health care facility costs and to allow coordinated planning of new services and construction. Laws authorizing such programs are one mechanism by which state governments seek to reduce overall health and medical costs. Many "CON" laws were put into effect across the nation as part of the federal "Health Planning Resources Development Act" of 1974. Despite numerous changes in the past 30 years, about 36 states retain some type of CON program, law or agency as of mid-2006.

TABLE OF CONTENTS

HISTORY

In 1964, New York became the first state to enacted a statute granting the state government power to determine whether there was a need for any new hospital or nursing home before it was approved for construction. Four years later the American Hospital Association expressed an interest in Certificate of Need laws. The AHA started a national campaign for states to generate their own CON laws. By 1975, 20 states had enacted CON laws; by 1978, 36 states had enacted them.

The 1974 federal Act required all 50 states to submit proposals and obtain approval from a state health planning agency before beginning any major capital projects such as building expansions or ordering new high-tech devices. Many states implemented CON programs in part because of the incentive of federal funds.

The federal mandate was repealed in 1987, along with its federal funding. In the decade that followed, 14 states discontinued their CON programs.However, 36 states currently maintain some form of CON program, and even the 14 that repealed their state CON laws still retain some mechanisms intended to regulate costs and duplication of services. Puerto Rico and the District of Columbia also have CON programs.

States that have retained CON programs currently tend to concentrate activities on outpatient facilities and long-term care. This is largely due to the trend toward free-standing, physician owned facilities that constitute an increasing segment of the health-care market.

INTENT

The basic assumption underlying CON regulation is that excess capacity (in the form of facility overbuilding) directly results in health care price inflation. When a hospital cannot fill its beds, fixed costs must be met through higher charges for the beds that are used. Bigger institutions have bigger costs, so CON supporters say it makes sense to limit facilities to building only enough capacity to meet actual needs.

CON programs originated to regulate the number of beds in hospitals and nursing homes, and to prevent overbuying of expensive equipment. Mandatory regulation through health planning agencies determined the most urgent health care needs, contributed to solutions for these needs, and attempted to manage the fluctuations in prices often caused by a competitive market. The idea was that new or improved facilities or equipment would be approved based only on a genuine need in a community. Statutory criteria often were created to help planning agencies decide what was necessary for a given location. By reviewing the activities and resources of hospitals, the agencies made judgments about what needed to be improved. Once need was established, the applicant organization (corporation, not-for-profit, partnership or public entity) was granted permission to begin a project. These approvals were known as "Certificates of Need."

C.O.N. SUPPORTERS' VIEWS	C.O.N. OPPONENTS' VIEWS
Advocates of CON programs say that health care cannot be considered as a "typical" economic product. They argue that many "market forces" do not obey the same rules for	CON programs also have been subject to wide criticism. To start, it is not clear that these state-sponsored programs actually controlled health care costs. For example, by restricting new construction, CON

health care services as they do for other products. In support of this argument, it is often pointed out that, since most health services (like an x-ray) are "ordered" for patients by physicians, patients do not "shop" for these services the way they do for other commodities. This makes hospital, lab and other services insensitive to market effects on price, and suggests a regulatory approach based on public interest.

The American Health Planning Association (AHPA) is the professional group of state agencies responsible for regulation and planning. They identify three factors that suggest the need for CON programs. The primary argument is that CON programs limit health-care spending. CONs can promote appropriate competition while maintaining lower costs for treatment services. The AHPA argues that by controlling construction and purchasing, state governments can oversee what expenditures are necessary and where funds will be used most effectively. This helps eliminate projects that detract attention from more urgent and useful investments and reduces excessive costs. AHPA also asserts that CONs have a valuable impact on the quality of care. When facilities and equipment are monitored, hospitals and other treatment centers can acknowledge what sort of services are in demand and how effectively patients are being taken care of. Additionally, according to supporters, the programs distribute care to areas that could be ignored by new medical centers. CON programs are a resource for policymakers. CON regulations are described as a reliable way to implement basic planning policies and practices, and aid in distributing health care to all demographic areas. The CON process can call attention to areas in need because planners can track and evaluate the requests of hospitals, doctors and citizens and see which areas are underserved or need to be improved and developed.

programs may reduce price competition between facilities, and may actually keep prices high. Barriers to new building were seen as unfair restrictions, sometimes by both existing facilities and their potential new competitors. There is little direct broad proof that overcapacity or duplication leads to higher charges. In 2004 the Federal Trade Commission (FTC) and the Department of Justice both claimed that CON programs actually *contribute* to rising prices because they inhibit competitive markets that should be able to control the costs of care and guarantee quality and access to treatment and services. *(1)*

Some opponents felt that changes in the Medicare payment system (such as paying hospitals according to Diagnostic Related Groups – "DRGs") would make external regulatory controls unnecessary, because health care organizations would be more subject to market pressures. Some pointed out that the CON programs are not consistently administered. A 'flexible' program could allow development, to the dismay of competitors. A 'restrictive' program could limit competition, with the same effect. Many argued that health facility development should be left to the economics of each institution, in light of its own market analysis, rather than being subject to political influence.

Some evidence suggests that lack of competition paradoxically *encouraged* construction and additional spending. Some opponents of CON programs believe an open health care market, based on quality rather than price, might be the best principle for containing rising costs. Proponents of CON programs disagree. This debate rests on the same arguments as many other "Regulated market" vs. "Open market" discussions.

In theory, Certificates of Need are granted based on objective analysis of community need, rather than the economic self-interest of any single facility. However, opponents of CON programs claim that the programs have not worked this way. They cite examples in which CONs were apparently granted on the basis of political influence, institutional prestige or other factors apart from the interests of the community. Furthermore, it is sometimes a matter of debate what sort of development is actually in the community's interest, with people of good will sharply divided on how to determine this.

Other Approaches

Many approaches have been tried to controlling health care costs, including government and industry regulation, provider incentives, "free market" incentives and educational efforts. Some of these include:

1. Limitations on physician referrals to facilities in which they or a family member have a financial interest (so-called "Stark regulations").
2. Supervision by insurers to make sure a treatment request is necessary (precertification, concurrent or retrospective medical necessity review).
3. Prepayment for insured or covered services ("managed care")
4. Fixed payments for defined services ("Information Individual Programs DRGs"- uniform Diagnostic-Related Groups)
5. Providing information to patients about the costs and necessity of certain tests and treatment (includes "transparency" and disclosure programs)
6. Providing information to patients about the quality of and outcomes at certain medical facilities.

Footnotes:

1. The Federal Trade Commission, Department of Justice, *Improving Health Care: A Dose of Competition* (Washington D.C.: FTC, DOJ, 2004) 361 pages PDF.

STATES WITH CON PROGRAMS

State Certificate of Need Laws, 2006

CON law: state approval may be required

CON law repealed or not in effect

Compiled by NCSL, based on data from AHPA, June 2006

State/District with CON Programs	Dates of Programs	Certificate of Need Contact Information	Individual CON Websites
Alabama	1977-present	**James E. Sanders,** Deputy Director Phone: 334-242-4103; Fax: 334-242-4113 james.sanders@shpda.alabama.gov	http://www.shpda.state.al.us
Alaska	1976-present	**David Pierce,** CON Coordinator Phone: 907-465-3001; Fax: 907-465-4101 david_pierce@health.state.ak.us	Alaska's Certificate of Need Program
Arizona	1971-1985		No CON Program; see planning agency below
Arkansas	1975-present	**Deborah Frazier,** Director Phone: 501-661-2509; Fax:501-661-2399 dfrazier@healthyarkansas.com	http://www.arhspa.org
California	1969-1987		No CON Program; see planning agency below
Colorado	1973-1987		No CON Program; see planning agency below
Connecticut	1973-present	**Susan Cole,** Director Phone: 860-418-7038; Fax: 860-418-7053 susan.colecngland@po.state.ct.us	Connecticut's Certificate of Need Program
Delaware	1978-present	**Francis Osei-Afriyie,** Management Analyst Phone: 302-741-2960; Fax: 302-741-2970 francis.osei-afriyie@state.de.us	Delaware's Certificate of Public Review Program
District of Columbia	1968-present	**Amaha Selassie,** Chief, Project Review Phone: 202-442-5875; Fax: 202-442-4824	DC Certificate of Need Website
Florida	1972-present	**Jeff Gregg,** Bureau Chief Phone: 850-922-8672; Fax: 850-488-6964 gregg@fdhc.state.fl.us	Florida Licensing and Certification
Georgia	1979-present	**Robert Rozier,** Esq., Executive Director Phone: 404-657-7198; Fax: 404-656-0554 rrozier@dch.ga.gov	Georgia's Certificate of Need Program
Hawaii	1974-present	**David Sakamoto,** MD, Administrator Phone: 808-587-0788; Fax: 808-587-0783 david@shpda.org	Hawai'i's Website for Certificate of Need
Idaho	1980-1983		No CON Program; see planning agency below
Illinois	1974-present	**Jeffrey Mark,** Health Planning Board Phone: 217-783-3516; Fax: 217-785-4308	http://www.idph.state.il.us/about/hfpb.htm

		jmark@idph.state.il.us	
Indiana	1980-1996, 1997-1999		No CON Program; see planning agency below
Iowa	1977-present	**Barb Nervig**, Program Manager Phone: 515-281-4344; Fax: 515-281-4958 bnervig@idph.state.ia.us	http://www.idph.state.ia.us/do/cert_of_need.asp
Kansas	1972-1985		No CON Program; see planning agency below
Kentucky	1972-present	**Chris Corbin**, Executive Director Phone: 502-564-9589; Fax: 502-564-0302	http://chfs.ky.gov/ohp/con
Louisiana	1991-present	**James Taylor**, Program Manager Phone: 225-342-3881; Fax: 225-342-3893 jmtaylor@bhh.la.gov	http://www.dhh.state.la.us/
Maine	1978-present	**Catherine Cobb**, Director Phone: 207-287-2979; Fax: 207-287-5282 catherine.cobb@maine.gov	Maine Certificate of Need Procedures Manual Maine Government Website
Maryland	1968-present	**Paul Parker**, Acting Chief Phone: 410-764-3261; Fax: 410-358-1311 pparker@mhcc.state.md.us	Maryland Certificate of Need Program
Massachusetts	1972-present	**Joan Gorga**, Acting Director Phone: 617-753-7340; Fax: 617-753-7349 Joan.Gorga@state.ma.us	http://www.state.ma.us/dph/dhcq/don.htm
Michigan	1972-present	**Larry Horvath**, Manager Phone: 517-241-3343; Fax: 517-241-2962 horvathl@michigan.gov	http://www.michigan.gov/con
Minnesota	1971-1985		No CON Program; see planning agency below
Mississippi	1979-present	**Rachel Pittman**, Chief, P&RD Phone: 601-576-7874; Fax: 601-576-7530 rachel.pittman@msdh.state.ms.us	Mississippi Certificate of Need Program
Missouri	1979-present	**Thomas Piper**, Director Phone: 5573-751-6043; Fax: 573-751-7894 tpiper@mail.state.mo.us	www.dhss.mo.gov/con
Montana	1975-present	**Pamela Sourbeer**, Administrative Officer Phone: 406-444-9519; Fax: 406-444-1742 psourbeer@mt.gov	Administrative Rules of Montana CON
Nebraska	1979-present	**Claire Titus**, Section Program Manager Phone: 402-471-4963; Fax: 402-471-3577 claire.titus@hhss.ne.gov	http://www.hhs.state.ne.us/crl/need.htm
Nevada	1971-present	**Lynn Solano**, Rn, Health Resource Analyst Phone: 775-684-4177; Fax: 775-684-4156 lsolano@nvdh.state.nv.us	http://www.health2k.state.nv.us/ss/letter.htm
New Hampshire	1979-present	**Margaret Heatley**, Administrator Phone: 603-271-4606; Fax: 603-271-4141 m.heatley@dhhs.state.nh.us	http://www.nhha.org/nhha/state_law/con.php
New Jersey	1971-present	**John Calabria**, Director Phone: 609-292-8773; Fax: 609-292-3780 john.calabria@doh.state.nj.us	(none) http://www.state.nj.us/health/hcsa/con-2_7a.pdf (application only)
New Mexico	1978-1993		No CON Program; see planning agency below
New York	1966-present	**Christopher Delker**, Program Research Sp Phone: 518-402-0966; Fax: 518-402-0971 cpd02@health.state.ny.us	http://www.health.state.ny.us/nysdoh/consumer.htm
North Carolina	1978-present	**Lee Hoffman**, Chief Phone: 919-855-3873; Fax: 919-733-8139 Lee.Hoffman@ncmail.net	http://facility-services.state.nc.us/
North Dakota	1971-1995		No CON Program
Ohio	1975-present	**Christine Kenney**, CON Director Phone:	Ohio CON webpage

		614-644-3325; Fax: 614-752-4157 christine.kenney@odh.ohio.gov	
Oklahoma	1971-present	**Darlene Simmons**, Director Phone: 405-271-9444; Fax: 405-271-7360 darlen@health.state.ok.gov	Oklahoma CON Abstract
Oregon	1971-present	**Jana Fussell**, CON Coordinator Phone: 503-731-4320; Fax: 503-731-4078 jana.fussell@state.or.us	Oregon CON Webpage
Pennsylvania	1979-1996		No CON Program; see planning agency below
Puerto Rico	1975-present		Consultant CON webpage
Rhode Island	1968-present	**Michael K. Dexter**, Chief, Office of Health Systems Development Phone: 410-222-2788; Fax: 410-273-4350 michael.dexter@health.ri.gov	http://www.health.ri.gov/hsr/healthsystems/index.php
South Carolina	1971-present	**Joel C. Grice**, Director Phone: 803-545-4200; Fax: 803-545-4570 grocjc@dhec.sc.gov	http://www.scdhec.gov/hr/cofn/
South Dakota	1972-1988		No CON Program; see planning agency below
Tennessee	1973-present	**Melane M. Hill**, Executive Director Phone: 615-741-2364; Fax: 615-741-9884 melanie.hill@state.tn.us	http://tennessee.gov/hsda/cert_need_sum.html
Texas	1975-1985		No CON Program; see planning agency below
Utah	1979-1984		No CON Program; see planning agency below
Vermont	1979-present	**Jennifer Garson**, CON Analyst Phone: 802-828-2900; Fax: 802-828-2949 jgarson@bishca.state.vt.us	Vermont CON program
Virginia	1973-present	**Erik Bodin**, Director Phone: 804-367-2126; Fax: 804-367-2206 Erik.Bodin@vdh.virginia.gov	http://www.cvhpa.org/CON.htm
Washington	1971-present	**Janis Sigman**, Manager Phone: 360-236-2955; Fax: 360-236-2901 janis.sigman@doh.wa.gov	Washington CON program
West Virginia	1977-present	**Dayle CON PlanningStepp**, CON Director Phone: 304-558-7000, Fax: 304-559-7001 dstepp@hcawv.org	http://www.hcawv.org/CertOfNeed/contname.htm
Wisconsin	1977-1978, 1993-present	**C. David Lund**, Chief, N.H. Section Phone: 608-266-2021; Fax: 608-264-7720 lundcd@dhfs.state.wi.us	Wisconsin Resource Allocation Program
Wyoming	1977-1989		No CON Program; see planning agency below

HEALTH PLANNING AGENCIES IN STATES WITHOUT CURRENT C.O.N. PROGRAMS

State	Dates of CON law	Planning Agency & Contacts	
Arizona	1971-1985	**Patricia Taranga**, Chief Phone: 602-542-1219; Fax: 602-542-2011 ptaranga@hs.state.az.us	No CON Program
California	1969-1967	**Jonathan M. Teague**, Manager Phone: 916-322-2814; Fax: 916-324-9242 jteague@oshpd.state.ca.us	No CON Program
Colorado	1973-1987	**Susan Rehak**, Contact Phone: 303-692-2470; Fax: 303-782-5576 susan.rehak@state.co.us	No CON Program
Idaho	1980-1983	**Jane Smith**, Chief Phone: 208-334-5976; Fax: 208-332-7303 smithj2@idhw.state.id.us	No CON Program
Indiana	1980-1996, 1997-	**Tom Reed**, Public Health Administrator Phone:	No CON Program

	1999	317-233-7541; Fax: 317-233-7157 treed@isdh.state.in.us	
Kansas	1972-1985	**Richard J. Morrissey**, Interim Director Phone: 785-296-1343; Fax: 785-296-1562 rmorriss@kdhe.state.ks.us	No CON Program
Minnesota	1971-1985	**Sheila Brunelle**, Principal Planner Phone: 651-282-3853; Fax: 651-297-5808 sheila.brunelle@health.state.mn.us	No CON Program
New Mexico	1978-1983	**Karen Meader**, Deputy Director Phone: 505-424-3200; Fax: 505-424-3222 kmeader@hpc.state.nm.us	No CON Program
North Dakota	1971-1995	**Gary Garland**, Contact Phone: 701-328-2894; Fax: 701-328-1890 ggarland@state.nk.us	No CON Program
Pensylvania	1979-1996	**Michelle S. Davis**, Deputy Secretary Phone: 717-783-8804; Fax: 717-772-6959 msdavis@state.pa.us	No CON Program
South Dakota	1972-1988	**Doneen Hollingsworth**, Secretary Phone: 605-773-3361; Fax: 605-773-5683 doneen.hollingsworth@state.sd.us	No CON Program
Texas	1975-1985	**Connie Turney**, Project Director Phone: 512-458-7261; Fax: 512-458-7344 connie.turney@dshs.state.tx.us	No CON Program
Utah	1979-1984	**Scott Williams**, MD, MPH, Executive Director Phone: 801-538-6111 sdwilliams@utah.gov	No CON Program
Wyoming	1977-1989	**Morris Gardner**, Senior Advisor Phone: 307-777-7656; Fax: 307-777-7439 mgardn@state.wy.us	No CON Program

Contact information obtained from American Health Planning Association National Directory, 2006 edition.

FACILITIES AND SERVICES REGULATED BY C.O.N.

Regulated Services	States, with Districts & Commonwealth
Acute Hospital Beds	AL, AK, CT, DE, FL, GA, HI, IL, KY, ME, MD, MI, MS, MO, NV, NH, NJ, NY, NC, RI, SC, TN, VT, VA, WA, WV, DC, PR
Air Ambulance	AK, CT, HI, ME, MA, MI, NC, TN, VT
Ambulatory Surgical Centers	AL, AK, CT, DE, GA, HI, IL, IA, KY, ME, MD, MA, MI, MS, MT, NV, NH, NY, NC, RI, SC, TN, VT, VA, WA, WV, DC, PR
Assisted Living *(also see Residential Care, below)*	AK
Behavioral Health	WV
Birthing Centers	DE
Burn Care	AK, CT, FL, HI, IL, ME, MD, NJ, NY, NC, VT, WA, WV
Business Computers	CT, VT, WV
Cardiac Catheterization	AL, AK, CT, DE, GA, HI, IL, IA, KY, ME, MD, MI, MS, MO, NH, NJ, NY, NC, RI, SC, TN, VT, VA, WA, WV, DC
Computed Tomography (CT) Scanners	AK, CT, GA, HI, ME, MI, MO, NH, NY, NC, RI, TN, VT, VA, DC, PR
Gamma Knives	AL, AK, CT, GA, HI, IL, ME, MA, MI, MS, MO, NY, NC, RI, SC, VT, VA, WV, DC
Home Health	AL, AK, AR, GA, HI, KY, MD, MS, MT, NJ, NY, NC, SC, TN, VT, WA, WV, DC
Hospice	AL, AK, AR, CT, FL, IL, KY, MD, MS, NV, NY, NC, OH, TN, VT, WA, WV, PR
Hospital *(also see Acute Hospital, above)*	MI, MO
Intensive Care	NC

Intermediate Care Facilities/Mental Retardation (ICF/MR)	AR, FL, GA, HI, IL, IA, KY, LA, ME, MD, MS, MO, MT, NV, NJ, NY, NC, OK, SC, TN, VT, VA, WV, WI, PR
Long Term Acute Care (LTAC)	AL, AK, CT, DE, FL, GA, HI, IL, KT, ME, MD, MA, MI, MS, MO, NV, NH, NJ, NY, NC, RI, SC, TN, VT, VA, WA, WV, DC, PR
Lithotripsy	AL, AK, CT, DE, GA, HI, KY, ME, MA, MI, MS, MO, NH, NY, NC, SC, TN, VT, VA, WV, DC.
Long Term Care	AL, AK, AR, CT, DE, FL, GA, HI, IL, IA, KY, LA, ME, MD, MA, MI, MS, MO, MT, NE, NH, NV, NJ, NY, NC, OH, OK, OR, RI, SC, TN, VT, VA, WA, WV, WI, DC, PR
Medical Office Buildings	CT, GA, DC
Medical Services for Indigents (MSI)	VA
Mobile Hi Technology (CT / MRI / PET, etc)	AK, CT, GA, HI, KY, ME, MI, MO, NH, NY, NC, RI, SC, VT, VA, WV, DC
Mobile Medical Services	KY
Magnetic Resonance Imaging (MRI) Scanners	AL, AK, CT, GA, HI, KY, ME, MA, MI, MS, MO, NH, NY, NC, RI, SC, TN, VT VA, WV, DC
Neo-Natal Intensive Care	AL, AK, CT, FL, GA, HI, IL, KY, ME, MD, MA, MI, NJ, NY, NC, RI, SC, TN, VT, VA, WA, WV, DC
Obstetrics Services	AL, AK, CT, GA, HI, IL, ME, MD, NY, RI, SC, VT, VA, WA, WV, DC
Open Heart Services	AL, AK, CT, FL, GA, HI, IL, IA, KY, ME, MD, MA, MI, MS, MO, NH, NJ, NY, NC, RI, SC, TN, VT, VA, WA, WV, DC
Organ Transplants	AL, AK, CT, FL, GA, HI, IL, IA, KY, ME, MD, MA, MI, MO, NJ, NY, NC, RI, VT, VA, WA, WV, DC
Positron Emission Tomography (PET) Scanners	AL, AK, CT, DE, GA, HI, IL, IA, ME, MA, MI, MS, MO, NH, NY, NC, RI, SC, TN, VT, VA, WV, DC, PR
Psychiatric Services	AL, AK, CT, FL, GA, HI, IL, KY, ME, MD, MA, MI, MS, NH, NJ, NY, NC, OK, RI, SC, TN, VT, VA, WV, DC, PR
Radiation Therapy	AL, AK, CT, DE, GA, HI, IL, IA, KY, ME, MD, MA, MI, MS, MO, NH, NY, NC, RI, SC, TN, VT, VA, WV, DC
Rehabilitation	AL, AK, CT, GA, HI, IL, KY, ME, MD, MA, MS, MT, NE, NV, NH, NJ, NY, NC, RI, SC, TN, VT, VA, WA, WV, DC
Renal Failure/Dialysis	AL, AK, HI, IL, ME, MS, MO, NY, NC, VT, WA, WV, DC
Assisted Living & Residential Care Facilities	AK, AR, CT, GA, KY, MA, MS, MO, NJ, NY, NC, WV
Single Photon Emission Computed Tomography (SPECT)	VA
Subacute Services	AK, AR, FL, GA, HI, IL, KY, MD, NV, OK, RI, SC, TN, WA, WI, DC
Substance/Drug Abuse	AL, AK, CT, FL, GA, HI, ME, MD, MA, MS, MT, NV, NH, NY, NC, OK, RI, SC, TN, VT, VA, WV, DC
Surgery *(also see Amulatory Surgical Centers)*	MI
Swing Beds	AL, AK, AR, CT, GA, HI, IL, ME, MI, MS, MT, NY, NC, OR, RI, TN, VT, WA, WV, DC
Ultra-Sound	AK, CT, ME, MO, NY
Other (Not otherwise covered)	AL, AR, CT, GA, IL, KY, MD, MA, MI, NC, OK, TN, WA, WI, PR

NOTE: The categories listed above are for general information. See state-specific limitations, exceptions and requirements.

CON Online Sources & Resources:

1. http://www.ahpanet.org/articlesessn.html Articles and essays collected from American Health Planning Association

2. [illegible] Opponent view of CON Program using Washington State as example.

3. www.ftc.gov The Federal Trade Commission website

4. http://www.ahpanet.org/websites.cfm.html American Health and Planning Association with other planning related websites and a list of websites for the CON programs of each state.

http://www.ahpanet.org/index.html

5. http://content.healthaffairs.org/cgi/reprint/hlthaff.25.w337v1

6. http://rss.net/tn.jsp?t=hxgabxbab.0.r8qvn8n6.ucoukvu6.124901&p=http%3A%2F%2Fwww.healthaffairs.org

7. Monopoly is not the Answer' an abstract of how regulations hav cted the markets. *Health Affairs*, August 9, 2005.

8. 'Effects of Physician-Owned Limited Service Hospitals: Evidence from Arizona' an abstract. *Health Affairs*, October 25, 2005.

9. 'Political Evolution of Federal Health Care Regulation' *Health Affairs*, Copyright 1992.

10. 'Specialty Versus Community Hospitals: What Role for the Law?' *Health Affairs*, August 9, 2005.

11. 'Rules of the Game: How Public Policy affects local Health Care Markets' *Health Affairs*, Copyright 1998.

12. http://www.law.fsu.edu/journals/lawreview/issues/231/loading.html

2005-06 Examples of CON State Legislation

State/Bill/Web link/Sponsor *yellow background=enacted*	Descriptions of Bills/Excerpts of bill text
AK HB 287 Rep. Lynn	An act amending the certificate of need requirements to apply only to health care facilities and nursing homes located in borough with a population of not more than 25,000, in the unorganized borough, or in a community with a critical access hospital. *(Filed 4/27/05; did not pass by end of regular session, 2006)*
CA* SB 6[illegible] Sen. Aan[illegible]rad	An act to amend Section 1250 of the Health and Safety Code, relating to health facilities. *(Filed 2/22/05; passed House 60y-4n, 9/8/05; passed Senate 44y-1n, 9/8/05; signed into law by Governor as Chapter 443, 9/30/05)*
CT HB 5242 Rep. Dillon	An examination of the State's current and future hospital bed capacity and hospital-based graduate medical education. *(Filed 2/16/06; did not pass by end of regular session, 2006)*
CT HB 5468 Public Hlth. Comm.	To increase the certificate of need threshold for all capital expenditures, including major medical equipment, to three million dollars. *(Filed 2/22/06; passed House 142y-0n 4/11/2006; passed Senate 35y-0n 4/21/06; signed into law by Governor 5/8/06)*
CT HB 5719 Public Hlth. Comm.	To make the certificate of need process for new or expanded emergency medical services clearer and more consistent. *(Filed 3/3/06; did not pass by end of regular session, 2006)*
CT SB [illegible] Public Hlth. Comm.	To allow certified or licensed emergency medical service providers to add one emergency vehicle to their service every three years without undergoing a needs assessment by the Office of Emergency Medical Services, to clarify the Commissioner of Public Health's responsibilities with respect to establishing methods for setting emergency service rates for certified ambulance services and to protect patients from the dangers of secondhand smoke while being transported to or from nonemergency medical services. *(Filed 2/22/06; did not pass by end of regular session, 2006)*
CT	To revise statutes pertaining to the Office of Health Care Access.

SB 386 Public Needelman WouldHlth. Comm.	*(Filed 2/23/06; passed Senate 33y-0n 4/20/06; passed House 146y-0n 4/28/06; signed into law by Governor 5/19/06)*
CT SB 621 Public Hlth. Comm.	To require the Department of Health to establish a standard set of exemptions for single specialty outpatient surgical facilities from licensure and certificate of need requirements. *(Filed 3/8/06; did not bass by end of regular session, 2006)*
FL HB 1565 Rep. Needelman	Would require county commissioners board to issue certificate of public convenience & necessity to any municipality that applies for such certificate to provide advanced life support transport or nontransport emergency medical services within its geographic limits or outside its geographic limits by mutual agreement with governing body of jurisdiction served, etc. *(Filed 3/8/05; died in committee 5/6/05)*
FL HB 1829	For Holmes County Hospital Corporation, amends special act and revises provisions regarding corporation's issuance of bonds to construct and erect new hospital facility in Holmes County; repeals various provisions of said special act. *(Passed House and Senate; signed into law by governor as Chapter No. 2005-352, 6/13/06)* |
FL HB 7051 Rep. Gibson	Extends moratorium on certificates of need for additional community nursing home beds until July 1, 2011; specifies nonapplication of moratorium for addition of nursing home beds in certain specified facilities; provides for repeal upon expiration of moratorium; exempts nursing home that is created by combining certain licensed beds from requirements for obtaining certificate of need from AHCA, etc. *(Filed 2/22/06; passed House 120y-0n 4/19/06; passed Senate 34y-0n 4/20/06; signed into law by Governor 6/9/2006)*
FL HB 7141 Rep. Garcia	Requires healthcare providers to display licenses; exempts nursing home created by combining certain licensed beds from requirements for obtaining certificate of need from AHCA; establishes trauma center startup grant program, etc. *(Filed 3/17/2006; passed House 114y-0n, 4/28/06; passed Senate 40y-0n, 5/4/06; signed into law by Governor 6/12/06)*
FL SB 1516 Sen. Wilson	Would create intergenerational respite care assisted living facility pilot program; provides duties of AHCA re program; provides requirements & standards for program; provides for rules; requires report to Legislature. *(Filed 2/15/05; did not pass by end of regular session, 2006)*
FL SB 2158 Sen.	Would amend provision re health-care-related projects subject to review for certificate of need; exempts class II specialty hospitals specializing in delivery of health services to pediatric patients from requirement to obtain certificate of need from AHCA; provides criteria for such exemption. *(Filed 2/16/06; died in committee 3/22/06; did not pass by end of regular session)*
GA HB 390 Rep. Scott	State Commission on the Efficacy of the Certificate of Need Program *(Filed 2/9/05; passed House 151y-0n 3/3/05; passed Senate 42y-0n, 3/22/05; signed into law by Governor 4/7/05)*
GA SB 24 Sen. Hudgens	Relates to the certificate of need program, so as to provide for an exemption from the certificate of need requirements for the voluntarily relocation of a health care facility under certain conditions; to provide for an exemption from the certificate of need requirements for the relocation, repair, or replacement of a health care facility that is damaged, destroyed, or rendered inoperable under certain conditions; to provide for related matters; to provide for an effective date; to repeal conflicting laws; and for other purposes. (Filed 2/23/05; did not pass by end of regular session, 2005)
HI HB 337 Rep. Evans	Exempts all long-term care facilities at all levels of care from the certificate of need process under the state health planning and development agency. *(Filed 1/20/2005; carried over to 2006 session 12/2/05)*
IL SB 505 Sen. Garrett	Amends the Illinois Health Facilities Planning Act. Provides that "capital expenditure minimum" means $10,000,000 (now, 6,000,000) and "non-clinical service area" includes research facilities, auditoriums, and medical office buildings. Provides that permits are not required for the establishment of swing-beds authorized under Title XVIII of the federal Social Security Act, or for the modification of a hospital's bed capacity. Provides that the Illinois Health Facilities Planning Act is repealed on July 1, 2011 (now July 1, 2006). Effective immediately. *(Filed 2/17/05; passed Senate 56y-0n 4/14/05; did not pass by end of regular session, 2005)*
IL SB 2436 Sen. Crotty	Amends the Illinois Health Facilities Planning Act. Requires inventories of certain skilled or intermediate care facilities to be conducted annually by July 1, to list services provided, and to differentiate between active and inactive beds. Effective immediately.

	(Filed 1/18/06; passed Senate 57y-0n 3/2/06; passed House 105y-4n 5/4/06; signed into law by Governor 6/30/06)
IN SB 161 Sen. Miller	Moratorium on comprehensive care beds. Imposes a moratorium on the construction or addition of comprehensive care beds through June 30, 2007, with certain exceptions. *(Filed 1/9/06; passed Senate 45y-2n 1/26/06; passed House 88y-0n 3/1/06; signed into law by Governor 3/20/06)*
IA HSB 614 SSB 3072 Chair Upmeyer	An Act relating to placing nursing facility beds in reserve. *(Filed 1/31/06; did not pass by end of regular session, 2006)*
KS HB 2799	Concerns adult care homes, relating to home plus beds. *(Filed 2/1/06; did not pass by end of regular session, 2006)*
KS HR 6036	Would Memorialize the Congress of the United States regarding the benefits of speciality hospitals. *(Filed and sent to committee, 4/29/06; did not pass by end of session, 6/06)*
KS S.R. 1856, SR 1862	Memorializes the U.S. Congress to continue the current federal moratorium on specialty hospitals. *(Filed 4/1/06; SR 1862 passed Senate 4/30/06)* |
KY SB 61 Sen. Kelly	To replace the Office of Certificate of Need with the Office of Health Policy for Health and Family Services. *(Filed 1/6/06; passed Senate 92y-3n, 3/24/06; passed House 4/11/06; signed into law by Governor in Acts Chapter 181, 4/18/06)*
LA HB 1337 Rep. Thompson	To provide for the certificate of rural necessity program. *(Filed 4/18/06; did not pass by end of regular session, 2006)*
LA SB 311 Sen. Hines	Provides for the needs assessment review for the approval of federally qualified healthcare centers. *(Filed 3/17/06; did not pass by end of regular session, 2006)*
LA SB 754 Sen. Cravins	Related to adult day healthcare providers and to provide for related matters. *(Filed 6/1/06; passed House 90y-0n, 6/16/06; passed Senate 32y-0n, 6/16/06; signed into law by Governor as Act 637, 6/23/06)*

ME HB 1254 LD 1614 Rep. Miller	Proposes to amend the certificate of need law to improve review procedures in the certificate of need program within the Department of Health and Human Services. *(Filed 12/28/2005; died in committee 4/26/06)*
ME HB 1315 LD 1875 Rep. Millett	Provides improved services to persons in rehabilitation programs; Directs the Department of Health and Human Services, Office of Substance Abuse to evaluate need when issuing licenses, etc. *(Filed 1/3/06; passed House 3/23/06; passed Senate 3/27/06; signed into law by Governor 3/30/06)*
ME SB 225 LD 678 Sen. Dow	An act to ensure access to swing beds in hospital *(Filed 2/10/05; died in committee 5/23/05)*
ME SB 490 LD 1401 Sen. Brennan	To further coordinate the laws regarding certificate of need, the state health plan and the Capital Investment Fund. *(Filed 3/22/05; passed House 6/8/05; passed Senate 6/8/05; signed into law by Governor 6/10/05)*
ME SB 701/LR 2677 LD 1793 Sen. Rosen	Requires the Department of Health and Human Services to allow construction contingency budgeting for capital projects that is consistent with industry standards in a certificate of need application. *(Filed 12/30/05; passed House 4/10/06; passed Senate 4/10/06; signed into law by Governor 4/13/06)*
ME SB 852 LD 2110 Comm. of HHS	Repeals the Hospital Cooperation Act of 1992; Enacts the Hospital and Health Care Provider Cooperation Act. *(Filed 4/13/06; passed House5/23/06; passed Senate5/23/06; signed into law by Governor 5/30/06)*
MD HB 1015/SB 832 Rep. Pendergrass	Altering the level of capital expenditures made by or on behalf of a hospital or a health care facility other than a hospital that requires a certificate of need, etc. *(Filed 2/9/06; passed House 4/1/06; passed Senate 4/1/06; Governor vetoed 5/26/06)*

MD HB 1105 Rep. Morhaim	Requiring the Maryland Health Care Commission to adopt rules and regulations for certification of need that provide consideration for hospital projects that incorporate the requirements for a high performance building; and requiring the Health Services Cost Review Commission, in the determination of reasonable rates for each facility, to take into account the costs of hospital projects that incorporate the requirements for a high performance building *(Filed 2/9/06; passed House 3/17/06; did not pass by end of regular session, 2006)*
MD HB 1420/SB 529 Rep. Smigiel	Repealing a specified requirement for a specified State health plan relating to the certificate of need program, etc. *(Filed 2/10/06; did not pass by end of regular session, 2006)*
MA S 1293 Sen. Moore	Determination of need for hospital beds. *(Filed 1/26/05; did not pass by end of regular session, 2005)*
MA S. 1299	Would study the delivery of specialty hospitals. *(Filed 1/5/05; did not pass by end of regular session, 3/20/06)*
MA S 2141 Public Hlth Comm.	Amends law regulating need for hospital beds. *(Filed 6/30/05; did not pass by end of regular session, 2006)*
MA HD 4853 Rep. Koutoujian	The Department of Public Health be required to hold public hearings before the removal of publicly-funded beds under the jurisdiction of the Commonwealth. *(Filed 12/19/05; did not pass by end of regular session, 2006)*
MN HF 1380/ SF 1297 Solberg	Human services; extends deadline for a nursing facility moratorium exception project in Aitkin County. *(Filed 2/28/05; did not pass by end of regular session, 2005)*
MN HF 1422 Rep. Bradley	To modifying license fees, state-operated services, nursing facility reimbursement, children and families programs, and other provisions; providing positive abortion alternatives; and appropriating money. *(Filed 2/28/05; did not pass by end of regular session, 2005)*
MN HF 1862 Rep. Abeler	Creates evidence-based practice standards, achieves cost-containment measures, allows discounted payments, modifies other health insurance provisions and appropriates money. *(Filed 3/16/05; did not pass by end of regular session, 2006)*
MN HF 3633 Rep. Westrom	Hospital construction and modification moratorium and public interest review requirements for hospitals eliminated. *(Filed 3/27/06; did not pa end of regular session, 2006)*
MN SF 2232/ HF 2360 Sen. Belanger	Nursing home bed moratorium exception project deadline extension. *(Filed 4/18/06; did not pass by end of regular session, 2006)*
MN SF 2576/ HF 3048 Sen. Sparks	Ambulance purchase and lease regulations; hospital construction proposals; alternative approval process, etc. *(Filed 5/26/06; passed House 5/20/06; passed Senate 5/20/06; signed into law by Governor 5/26/06)*
MS HB 0[illegible] Rep. Woods	Removes all except specialty hospitals from application of certificate of need law; Authorizes construction of new acute care hospital. *(Filed 1/3/06; died in committee 1/31/06)*
MS HB 296 Rep. Flaggs	Certificate of need; authorizes nursing home for disabled adults. *(Filed 1/5/06; died in committee 1/31/06)*
MS HB 452 Rep. Fillingane	Nursing homes may add up to 60 new beds if have 95% occupancy rate. *(Filed 1/6/06; died in committee 1/31/06)*
MS HB 457 Rep. Fillingane	Repeal sections 41-7-171 through 41-7-209 from Mississippi Code of 1972, which are the Mississippi Health Care Certificate of Need Law of 1979 etc. *(Filed 1/6/06; died in committee 1/31/06)*
MS HB 386 Rep. Holland	To amend sections 41-7-173 and 31-7-191 from Mississippi Code of 1972 regarding hospices requiring a health care certificate of need by the State Department of Health. *(Filed 1/10/06; died in committee 1/31/06)*
MS HB 599 Rep. Holland	To require the Division of Medicaid to allow certain faith-based assisted living facilities to participate in the Medicaid Assisted Living Waiver Program and related purposes. *(Filed 1/10/06; died in committee 2/28/06)*

MS HB 600 Rep. Robinson	Amends section 41-7-191 of Mississippi Code of 1972 to issue a certificate of need for the addition of hospital beds. *(Filed 1/10/06; died in committee 1/31/06)*
MS HB 601 Rep. Martinson	Amends section 41-7-191 of Mississippi Code of 1972 to authorize a health care certificate of need for ICF-MR beds in community living programs for developmentally disabled adults. *(Filed 1/10/06; died in committee 1/31/06)*
MS HB 1095 Rep. Young	For the State Department of Health to provide a health care certificate of need for Psychiatric Residential Treatment Facility beds to be transferred; etc. *(Filed 1/16/06; died in committee 1/31/06)*
MS HB 1221 Rep. Compretta	Relates to moving nursing home beds from one facility to another; etc. *(Filed 1/16/06; passed House 3/22/06; passed Senate 3/22/06; signed into law by Governor 3/29/06)*
MS HB 1231/HB 1232/HB 1234 Rep. Flaggs	Relates to an ambulatory surgical facility; certain offices of private physicians shall require certificates of need; Revises the list of activities that require certificates of need. *(Filed 1/16/06; died in committee 1/31/06)*
MS HB 1283 Rep. Baker	Specifies requirements for issuance of CON for relocation of a health care facility. *(Filed 1/16/06; died in committee 1/31/06)*
MS SB 2011/SB 2018 Sen. Thomas	Certificate of Need Program for ICF/MR beds in a community living program for developmentally disabled adults; Nursing facility beds at "Green House Model" campus located in Yazoo city. *(Filed 1/4/06; died in committee 1/31/06)*
MS SB 2455 Sen. Nunnelee	Certificate of Need Program for community living program for developmentally disabled adults in Madison County. *(Filed 1/10/06; died in committee 1/31/06)*
MS SB 2482 Sen. Thomas	Clarifies Certificate of Need Program for the relocation of a health care facility. *(Filed 1/12/06; died in committee 1/31/06)*
MS SB 2522 Sen. Jackson	Creates an establishment for the Home Health Agency in Kemper County. *(Filed 1/12/06; died in committee 1/31/06)*
MS SB 2593 Sen. Burton	Relates to certificates of need that will transfer ICF/MR and child psychiatric beds from one facility to another. *(Filed 1/13/06; died in committee 1/31/06)*
MS SB 2645 Sen. Brown	Medicaid reimbursement for nursing facility beds under Certificate of Need Programs in Columbus. *(Filed 1/13/06; died in committee 1/31/06)*
MS SB 2653 Sen. Lee	Relates to psychiatric treatment facility beds in Simpson County. *(Filed 1/16/06; died in committee 1/31/06)*
MS SB 2661 Sen. Burton	Clarifies definition of ambulatory surgical facilities under Certificate of Need Program. *(Filed 1/16/06; died in committee 1/31/06)*
MS SB 2675 Sen. Nunnelee	Revises definition of ambulatory surgical facilities and licensure under Certificate of Need Program. *(Filed 1/16/06; died in committee 1/31/06)*
MS SB 2691 Sen. Nunnelee	Relates to health care facility activities under Certificate of Need Program. *(Filed 1/16/06; died in committee 1/31/06)*
MS SB 2710 Sen. Dawkins	Would impose a certificate of need moratorium on specialized programs offered by hospitals. *(Filed 1/16/06; died in committee 1/31/06)*
MS SB 2764 Sen. Horhn	Would authorize a certificate of need program for a nursing facility in any underserved minority zip code area in the state. *(Filed 1/16/06; died in committee 1/31/06)*
MS SB 2859	Would move nursing home beds from one facility to another and to construct another facility. *(Filed 1/16/06; died in committee 1/31/06)*

Sen. Kirby	
MS SB 2959 Sen. Lee	Would transfer certificates of need from Hancock to Stone and other counties. *(Filed 1/16/06; died in committee 1/31/06)*
MO HB 1537 Rep. Shaaf	Refers to 'long-term care facilities' for the purpose of the Certificate of Need Program and limits application of certificate of need requirements to long-term care facilities. *(Filed 1/25/06; did not pass by end of regular session, 2006)*
NJ AB 1469 Asmb. O'Toole	Requires certain background checks for assisted living administrators and applicants for certificate of need. *(Filed 1/10/06; Referred to committee 2/2/06)*
NJ AB 2691 Asmb. Stanley	Prohibits granting certificates of need for hospital closures in service areas with high incidence of morbidity unless DHSS has plan to manage public health emergency. *(Filed 2/23/06; Referred to committee 2/27/06)*
NJ ACR 120/SCR 53 Asmb. Van Drew	Urges DHSS to allocate 25% of new slots that are available in FY 2006 under Enhanced Community Options waiver to assisted living program providers. *(Filed 1/17/06; Referred to committee 2/26/06)*
NY AB 3263 Rep. Gottfried	To amend the public health law, in relation to nursing home staffing levels. *(Filed 2/1/06; Referred to committee 2/1/06)*
NY AB 3266 Rep. Gottfried	To amend the public health law, in relation to a nurse staffing centers; Additional powers and duties for the Commissioner of Health; Authorizes such commissioner to establish an advisory committee to advise in related issues; etc. *(Filed 2/1/06; Referred to committee 2/1/06)*
NY AB 3928 Rep. Brennan	An act to amend the mental hygiene law, in relation to establishing minimum staffing ratios in facilities operated under the jurisdiction of the office of mental health. *(Filed 2/7/06; Referred to committee 2/7/06)*
NY AB 5346 Rep. Gottfried	An act to amend the public health law, in relation to hospital establishment. *(Filed 2/18/06; Referred to committee 2/18/06)*
NY AB 11920/ S 7494 Rep. Gottfried	Relates to the limitation on the number of continuing care retirement community beds in the state. *(Filed 6/16/06; passed House 6/23/06; passed Senate 6/23/06)*
NY SB 3949 Sen. Oppenheimer	Requires health commissioner to make certain findings concerning access to health care services as a prerequisite to approving applications for establishment, incorporation or construction of certain health care facilities. *(Filed 4/5/05; Referred to committee 4/4/05)*
NY SB 4572 Comm. for Public Hlth.	Establishes minimum staffing levels of types of various personnel in nursing homes throughout any particular day; creates the advisory council on nursing home staffing to make recommendations to the governor, legislature and commissioner of health on nursing home staffing; requires public disclosure by each nursing home of its staffing levels and reporting thereof to the department of health. *(Filed 4/15/05; Referred to committee 4/15/05)*
NY SB 6716/AB 8877	Relates to increasing availability of services in certain assisted living programs. *(Filed 6/15/05; passed Assembly 6/23/05; passed Senate 6/23/05; signed into law by Governor Chapter 593, 8/23/05)*
NY	The Commission on Health Care Facilities in the 21st Century report proposes major adjustments in existing facilities including closings and downsizing. **A Prescription for New York City's Health Care Crisis:** Recommendations of the New York City Council Hospital Closing Task Force. *(Report issued 11/06; implementation pending 1/07)*
NC HB 465 Rep. Culpepper	To amend the Certificate of Need Laws. *(Filed 3/24/05; referred to committee 4/6/05)*
NC HB 1160 Rep. Wright	To change the definition of "Critical Access Hospital" to conform to federal law. *(Filed 3/30/05; passed House 4/13/05; passed Senate 8/23/05; signed into law by Governor 9/02/05)*
NC HB 2115	To appropriate funds to the Department of Health and Human Services, Division of facility services, to enhance fair and consistent application of the certificate of need law and health planning process.

Rep. Nye	*(Filed 5/22/06; Referred to committee 5/23/06)*
NC SB 740 Sen. Rand	To amend the Certificate of Need Laws. *(Filed 3/21/05; passed House 7/13/05; passed Senate 8/16/05; signed into law by Governor 8/26/05)*
NC SB 1161/HB 1112 Sen. Apodaca	Requires the Department of Health and Human Services to develop a central registry of available beds in mental health facilities to assist in the placement of individuals involuntarily committed to the facilities. *(Filed 3/23/05; did not pass by end of regular session, 2006)*
PA HB 2443 Rep. Killian	Relates to health care; delegating responsibilities to the State Health Coordinating Council, etc., providing certificates of need for health care providers and prescribing penalties, etc. *(Filed 2/8/06; Referred to committee 6/13/06)*
PA SB 1253 Sen. Greenleaf	Exempts continuing care retirement communities from the medical assistance bed approval process and allowing nursing facilities operated by continuing care retirement communities to obtain medical assistance certified beds under limited terms and conditions. *(Filed 6/22/06; Referred to committee 6/22/06)*
RI HB 5868 Rep. Landroche	Relating to Businesses and Professions, Board of Medical Licensure and Discipline, and self-referral. *(Filed 3/1/05; Did not pass by end of regular session, 2005)*
RI HB 5870 Rep. Lewiss	Relates to health and safety and the licensing of health care facilities. *(Filed 3/1/05; Did not pass by end of regular session, 2005)*
RI HB 5915 Rep. Savage	Relates to determination of need for new health care equipment and new institutional health care institutions. *(Filed 3/1/05; Did not pass by end of regular session, 2005)*
RI HB 7622 Rep. Long	Relates to determination of need for new health care equipment and new institutional health care institutions. *(Filed 2/16/06; Did not pass by end of regular session, 2006)*
RI HB 8058 Rep. Long	Determination of Need for New Health Care Equipment and New Institutional Health Services *(Filed 5/2/06, passed House6/22/06; passed Senate 6/23/06); signed into law by Governor, 7/5/06)*
RI HB 8246 Rep. Slater	Amends the definitions section, review and approval section, procedures for review section, and application fees section in the "Determination of Need for New Health Care Equipment and New Institutional Health Services" *(Filed 6/15/06; Did not pass by end of regular session, 2006)*
RI SB 426 Sen. Gibbs	To analyze applications for certificate of need. *(Filed 2/10/05; Did not pass by end of regular session, 2005)*
RI SB 784 Sen. Roberts	Amends sections in the Determination of Need for New Health Care Equipment and New Institutional Health Services. *(Filed 2/17/05; Did not pass by end of regular session, 2005)*
RI SB 796 Sen. Badeau	Relates to self-referral by medical practitioners; remove the capital cost test for application/installation of radiologic equipment. *(Filed 2/17/05; Did not pass by end of regular session, 2005)*
RI SB 2741 Sen. Roberts	To reduce the size and make-up of the health services council. *(Filed 2/14/06; passed House 6/23/06; passed Senate 6/22/06; signed into law by Governor 7/5/06)*
SC HB 3601/SB 592 Rep. Pitts	Relates to the State Health Planning Committee including the development and contents of the state health plan for use in the Administration of the Certificate of Need Program, so as to require the state health plan to include a provision that the Department of Health and Environmental Control shall approve a certificate of need application for open heart surgery if the applicant meets certain criteria. *(Filed 2/22/05; Referred to committee 2/22/05)*
SC SB 1053 Sen. Peeler	Relates to the State Health Planning Committee including the development and contents of the state health plan for use in the approval of certificates of need, including a certificate of need for methadone treatment facilities; provides that a certificate of need is required for the acquisition of certain medical equipment. *(Filed 1/18/06; Referred to committee 1/19/06)*
SC SB 1296	Relates to certificate of need requirements for home health agencies, so as to exempt from these requirements private duty home care agencies that participate in state-funded waiver programs, that

Sen. Hutto	continuously have provided these services since January 1, 2001, and that are accredited by the Joint Commission for the accreditation of health care organizations. *(Filed 3/16/06; Referred to committee 3/16/06)*
TN HB 228/SB 1751 Rep. Overbey	To increase state expenditures to the extent the replacement facility increases the nursing home bed pool, there could be an increase in the number of beds. Such an increase could result in an increase in expenditures exceeding $1,000,000 ($360,000 in state fund and $640,000 in federal funds). *(Filed 2/1/05; passed House 94y-0n, 5/22/05; passed Senate 32y-0n, 5/4/05; signed into law by Governor as Chapter 385, 5/23/05)*
TN HB 1088/SB 1007 Sen. Ford	Concerns hospitals and health care facilities; revises certificate of need requirements for relocation and partial replacement of nursing home beds and facilities. *(Filed 2/4/05; passed House 93y-0n 5/27/05; passed Senate 30y-0n 5/19/05; signed into law by Governor as Public Chapter 445, 6/24/05)*
TN HB 1112/SB 687 Rep. McMillan	Prohibits issuance of certificates of need for new nursing home beds between July 1, 2005 and June 30, 2007, except for certain Medicare skilled nursing facility beds. *(Filed 2/4/05; passed House 97y-0n, 5/12/05; passed Senate 31y-on, 4/28/05; signed into law by Governor as Chapter 237, 5/27/05)*
TN HB 1986/ SB 2113 Rep. Harmon	Exempts PACE program from certificate of need required to provide nursing home *(Filed 2/17/05; Referred to committee 3/30/05)*
TN HB 2010/SB 2103 Sen. Strader	Imposes a one-year moratorium on certificates of need for non-residential methadone treatment facilities. *(Filed 2/17/05; Referred to committee 4/17/05)*
TN HB 2211/SB 1551 Rep. Buck	Changes the maximum time allowed for reviewing agencies to report concerning a certificate of need application to the health services and development agency from 60 to 50 days. *(Filed 2/3/05; Did not pass by end of regular session, 2005)*
TN HB 3324/SB 3349 Rep. Finney	Clarifies that applications for a certificate of need shall be filed within five business days from the date of publication of the letter of intent *(Filed 2/16/06; Referred to committee 3/5/06)*
TN SB 2958/HB 3026 Sen. Cooper	Increases the total number of beds in ICF/MR facilities that have been providing state-contracted services to persons with developmental disabilities for at least five years by 50 beds per year for the next four years after July 1, 2006. This change would result in a maximum of 868 beds by June 30, 2009. *(Filed 2/17/06; passed House 98y-0n 5/11/06; passed Senate 32y-0n 4/20/06; signed into law by Governor as Chapter 761, 5/25/06)*
VT HB 35 Rep. Obuchowski	Health; health care administration; health facilities; discontinuance of services; licensing of hospitals; open meetings; public records; certificate of need; hospital budgets. *(Filed 1/13/05; Referred to committee 1/13/05)*
VT HB 459 Rep. Hube	To reform Vermont's Certificate of Need Laws. *(Filed 3/8/05; Referred to committee 3/8/05)*
VT HB 567 Rep. Keenan	Relates to exemption from certificates of need and HMO requirements for PACE. *(Filed 1/20/06; passed House 2/3/06; passed Senate 2/3/06; signed into law by Governor 2/15/06*
VA HB 267 Rep. Cole	Authorizes the submission of an application for an increase in nursing home beds, either on-site or through relocation within the same city or county, for a facility that was licensed for less than 40 beds under certain specific conditions. *(Filed 1/4/06; passed House 98y-1n, 2/14/06; passed Senate 40y-0n, 3/7/06; signed into law by Governor as Chapter 816, 4/6/06)*
VA HB 381 Rep. Suit	The bill authorizes the facility to request an amendment to its previous certificate of public need to admit persons, other than residents of the cooperative units, to its nursing home facility beds. The facility must be: (i) operated by an association described in § 55-458; (ii) created in connection with a real estate cooperative; and (iii) providing its residents a level of nursing services consistent with the definition of continuing care in Chapter 49 (§ 38.2-4900 et seq.) of Title 38.2. *(Filed 1/6/06; passed House 94y-0n, 1/24/06; passed Senate 40y-0n; 3/6/06; signed into law by Governor as Chapter 776, 4/6/06)*
VA HB 1139 Rep. Cline	Requires the Board of Health to develop staffing regulations specific to entities that are concurrently licensed as a hospice and an assisted living facility that would not require the presence on each shift of a registered nurse for any concurrently licensed facility that has no more than four beds and operates

	within an integrated healthcare system. *(Filed 1/11/06; Died in committee 1/24/06)*
VA HB 2243 Rep. O'Bannon	Revises the designation of the parties to the case if an informal fact-finding conference is determined to be necessary by the Department of Health or is requested by a person seeking good cause standing. In such cases, the designation of the parties to the case will include the relevant health planning agency. *(Filed 1/11/05; passed House 96y-0n, 2/7/05; passed Senate 40y-0n 2/22/05; signed into law by Governor as Chapter 404, 3/21/05)*
VA HB 2316 Rep. Griffith	Certificate of Public Need; relocation of certain nursing home beds under limited circumstances. *(Filed 1/11/05; passed House 79y-17n, 1/26/05; passed Senate 38y-1n, 2/21/05; signed into law by Governor as Chapter 99, 3/24/05)*
VA HB 2639 Rep. Hurt	Requires the Commissioner of Health to reissue a Request for Applications for 60 new nursing home or nursing facility beds in Planning District 12 when the scheduled construction date has passed, the company issued a certificate pursuant to a 1997 Request for Applications has not begun construction, and the certificate has expired. *(Filed 1/12/05; passed House 97y-0n, 2/1/05; passed Senate 40y-0n, 2/14/05; signed into law by Governor as Chapter 838, 3/26/05)*
VA HB 2626/ SB 1237 Rep. Orrock	Authorizes DMHMRSAS to license providers of services under the Medicaid Brain Injury Waiver and providers of residential services for persons with brain injury. The bill requires the State Board of Mental Health, Mental Retardation and Substance Abuse Services to promulgate necessary regulations within 280 days of enactment. *(Filed 1/19/05; passed House 94y-2n, 2/8/05; passed Senate 40y-0n, 2/22/05; signed into law by Governor as Chapter 725, 3/25/05)*
VA SB 426 Sen. Lambert III	Defines "reduced rate," for the purpose of the Commissioner's conditions on approval of a certificate of need. *(Filed 1/11/06; Died in committee 1/19/06)*
VA SB 839 Sen. Cuccinelli	Requires the regulation of abortion clinics as a category of outpatient surgical hospital and sets forth the requirements for the licensure of abortion clinics in a new article. Abortion clinics will not be required to comply with certificate of public need requirements or health care data reporting. The provision becomes effective on January 1, 2006. *(Filed 1/3/05; Referred to committee 2/3/05)*
WA HB 1688 Rep.	Creating a task force to review the certificate of need program and the health care facilities bonding program. *(Filed 2/2/05; passed House 71y-25n, 3/14/05; passed Senate 34y-11n, 4/7/05; signed into law by Governor as Chapter 283, 5/4/05)*
WA SB 5178	Establishes a moratorium on licensing physician owned specialty hospitals, from Jan 1, 2005 to July 1, 2006. *(Filed 1/17/05; passed Senate and House; signed into law by governor as Chapter 39, 4/13/06)*
WA SB 6278	Relates to licensing specialty hospitals. *(Filed 1/10/06; favorable report 2/1/06; did not pass by end of session 3/06)*
WV HB 4082 Rep. Amores	Establishing standards for and guidance to the West Virginia Health Care Authority in amending and modifying certificate of need standards. *(Filed 2/21/06; Referred to committee 2/21/06)*
WV SB 569 Sen. Caruth	Exempting ventilator beds from certificate of need requirement. *(Filed 2/15/06; Referred to committee 2/15/06)*
WV SB 765 Sen. Bowman	Authorizing certain nursing homes to obtain certificates of need for additional beds. *(Filed 2/20/06; Referred to committee 2/20/06)*
WV SB 773 Sen. Kessler	Establishes certificate of need standards. *(Filed 2/22/06; passed House 3/10/06; passed Senate 3/1/06; signed into law by Governor as Chapter 101, 3/23/06)*
WY SB 57	Provides for a study of medical specialty centers and new general hospitals by the Wyoming health care commission. Provides a temporary moratorium on licensing of new hospitals or medical specialty centers, requires a report by November 2006; provides an appropriation. *(Filed 1/24/06; passed Senate and House; signed into law by governor as Chapter 112, 3/24/06)*

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Research and updates under the direction of Richard Cauchi, Health Program Director, Denver, Colorado

Back to: NCSL Health Finance | Health Menu

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LEGISLATIVE RESEARCH REPORT

JANUARY 30, 2008

REPORT NUMBER 08.127

ALASKA'S STATE HEALTH PLANS

PREPARED FOR REPRESENTATIVE SHARON CISSNA

BY CHUCK BURNHAM, LEGISLATIVE ANALYST

You asked that we identify Alaska's current statewide health plans. You also asked that we provide information on the integration of the state plans with those of the Alaska Native Tribal Health Consortium (ANTHC).[1] In addition, you wanted us to identify states that have undertaken processes that have resulted in successful strategic health plans.

[1] We have requested a copy of the ANTHC strategic plan and will include that document as an addendum to this report when it becomes available. It appears that the ANTHC coordinates its efforts, to some extent, with the state as evidenced by the Department of Health and Social Service's website at *http://hss.state.ak.us/dph/targets/ha2010/volume3/summaries/ANTHCplan.htm*. The Department maintains a reference list of Native Health organizations online at *http://www.hss.state.ak.us/dph/targets/ha2010/volume3/native_ref.htm*.

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SUMMARY

Alaska's current state health planning regime began in the early 1990s through the framework of the federal "Healthy People 2000" program. Under that model, broad-based assessments of the health status indicators of Alaskans were conducted. These assessments served as the baseline health measures against which goals and objectives were established through a grant from the Robert Wood Johnson Foundation's "Turning Point" collaborative, which, in turn, spurred the creation of the Alaska Public Health Improvement Process. These earlier activities served as the foundation for the development of the state's current health plans under the "Healthy People 2010" model.

Two overarching documents currently supply the primary framework for Alaska's public health planning.[2] First, "Healthy Alaskans 2010," consisting of three volumes, contains goals and objectives for twenty-six health "problem areas." Cumulatively, the chapters associated with those areas have been the basis for numerous—at least 38—individual implementation plans and specific program plans. Second, "Moving Forward" is the state's comprehensive integrated mental health plan, which is required as a separate document under Alaska statute.

In the timeframe allowed for this report, we were unable to conduct extensive assessments of other states' planning processes. We do identify, however, publications that discuss "best practices" for cross-disciplinary collaborative planning processes, and we attach documents that examine the experiences of selected states in public health planning and improvement. In addition, we include links to online resources through which you may review assessments of numerous states' activities in specific areas of public health planning and practice.

TURNING POINT

According to Alice Rarig, Health Planner IV, Alaska Department of Health and Social Services (DHSS), Alaska's current health planning regime began in 1999 with the state's involvement with the "Turning Point" collaborative.[3] Formed in 1997, Turning Point is described on the organization's website as follows:

> Turning Point is an initiative of The Robert Wood Johnson Foundation and the W.K. Kellogg Foundation. Its mission was to transform and strengthen the public health system in the United States by making it more community-based and collaborative. The initial idea for Turning Point came from the foundations' concerns about the capacity of the public health system to respond to emerging

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[2] A third document—the Medicaid State Plan—also serves as a vital component of overall statewide health planning. This plan, however, largely concerns the means of financing aspects of the state's plans, and addresses the technical aspects and requirements of federal Medicaid law. The document is, in our view, a detailing of the means of executing health policy rather than a planning document, per se. The plan can be found online at *http://www.hss.state.ak.us/commissioner/medicaidstateplan/Default.htm#top*.

[3] Ms. Rarig can be reached at (907) 465-1285. Extensive information on Turning Point is available on the organization's website at *http://www.turningpointprogram.org/index.html*. Alaska's involvement inTurning Point is conducted by the Department of Health and Social Services. Additional information on the state's current Turning Point activities are available online at *http://hss.state.ak.us/dph/improving/turningpoint/default.htm*, and from Patricia Nault (907-465-8617), Health Program Manager II, who serves as the state's coordinator for the project.

challenges in public health, specifically the system's capacity to work with people from many sectors to improve the health status of all people in a community.

Turning Point's underlying philosophy was that public health agencies and their partners can be strengthened by linking to other sectors (not just the private health care sector, but education, criminal justice, faith communities, business, and others) because the underlying causes of poor health and quality of life are tied closely to social issues that are too complex to be approached by disease models of intervention.

Turning Point specifically collaborated with its 23 state partners to pursue the following overarching actions:

- Influence good public health policy
- Expand information technology so data is available to local communities for addressing health concerns
- Stimulate state agencies and organizations to develop comprehensive state health plans

The state's involvement with Turning Point resulted in the formulation of the Alaska Public Health Improvement Process (APHIP), which the DHSS describes as follows:

> APHIP is a planning process implemented to develop a better understanding of Alaska's public health system and infrastructure, to identify weaknesses in the system, and to set goals and develop strategies for strengthening the state's public health infrastructure. This process was supported by a grant from the Robert Wood Johnson Foundation from April 1997-March 1999. It resulted in a successful application to the Foundation for subsequent implementation funds to support creation of an Alaska Public Health Information System, to lead a national initiative to modernize state public health law, and to participate in a national initiative to promote performance management in public health. Other goals identified through the public health improvement process, such as assurance of a well trained, competent public health workforce, are also currently being addressed by a number of public health system partners.[4]

HEALTHY ALASKANS 2010

Emerging out of the APHIP process, "Healthy Alaskans 2010" is the state-focused adaptation of "Healthy People 2010," the current national public health guidelines and objective developed by the U.S. Department of Health and Human Services.[5] According to the DHSS, Healthy People

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[4] *http://hss.state.ak.us/dph/improving/aphip/default.htm*

[5] In 1994, DHSS published a plan to assess the health status of Alaskans and to identify key actions to be taken in order to make progress on certain health indicators based on the framework provided by the national Healthy People 2000 program. The data from these assessments serve as the baseline health status indicators upon which the updated goals and new measures of Healthy People 2010 seek to improve. More information on Healthy People 2010 is available on the program's website at *http://www.healthypeople.gov/About/*.

2010 was "developed through a broad consultation process" and is "built on the best scientific knowledge" and is designed to measure health trends over time. The program has two-overarching goals, as follows:

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

Numerous states have followed the federal Healthy People framework in formulating their health plans and policies. This circumstance will likely continue, as grants from the Centers for Disease Control—on which many state public health programs depend—are often tied to meeting the priorities and objectives of the program.

The development of Healthy Alaskans 2010 was guided by the Healthy Alaskans Partnership Council (formerly the APHIP Steering Committee). The Council was comprised of representatives of at least 32 organizations including state agencies, health care associations, the state university system, the military, Native health organizations, private health provider agencies, and the legislature. Under the Council's guidance three volumes were produced under the Healthy Alaskans 2010 title. Volume I is comprised of twenty-six "problem-area" chapters, authored primarily by DHSS staff, that each provide information, objectives and targets for a unique public health issue area.[6] Volume II is the strategic plan for the project; however, the volume employs the novel approach of using anecdotes and stories from communities across Alaska to impart the importance and relevance of each of the volume's chapters and issue areas.

Whereas volumes I & II of Healthy Alaskans provide the framework for the state's public health regime, volume III contains at least 38 specific program plans that are currently in effect in the state. Each of these plans relates to the objectives, targets and strategies of one or more of the issue areas delineated in volumes I & II of the series.[7]

COMPREHENSIVE INTEGRATED MENTAL HEALTH PLAN

The DHSS, in conjunction with the Alaska Mental Health Trust Authority (AMHTA), is required by AS § 47.30.660 to "prepare, and periodically revise and amend, a plan for an integrated comprehensive mental health program." The current plan, "Moving Forward," covers the years 2006-2011, and was "coordinated with federal, state, regional, local, and private entities involved in mental health services," as is required by statute.[8] The DHSS and the AMHTA specifically acknowledge the contributions to the report of the Alaska Commission on Aging, the Governor's Council on Disabilities and Special Education, the Governor's Advisory Board on Alcoholism and Drug Abuse, and the Alaska Mental Health Board. In the view of the authors, the involvement of these groups "assures that the Comprehensive Integrated Plan is consistent with the planning

[6] We include copies of Healthy Alaskans Volumes I & II as Attachment A. Volume III is available online at *http://hss.state.ak.us/dph/targets/ha2010/volume3/default.htm*

[7] The DHSS maintains a table for cross-referencing individual program plans to the 26 chapters of Healthy Alaskans volume I online at *http://hss.state.ak.us/dph/targets/ha2010/volume3/chapters.htm*

[8] We include a copy of "Moving Forward" as Attachment B. Additional information and electronic copies of the plan are available at *http://www.hss.state.ak.us/commissioner/healthplanning/movingforward/default.htm*. More information on the Alaska Mental Health Trust Authority is available online at *http://www.mhtrust.org/*

efforts" of statutory advisory and advocacy boards." According to the authors, the intent of the plan is as follows:

> . . . to guide resource allocation decisions in the development of services, workforce, and facilities to meet the needs of Trust beneficiaries. The overall goal is a service system that quickly meets the needs of each individual, where highly qualified staff from state, federal, tribal and private agencies have the resources necessary to work together to provide seamless care for the best outcome possible for each person. Another goal is to reduce the incidence of Trust beneficiaries' disabling conditions through prevention and early intervention, to the extent possible.

ALASKA HEALTH CARE STRATEGIES PLANNING COUNCIL

On February 15, 2007, Governor Palin issued Administrative Order 232, establishing the Alaska Health Care Strategies Planning Council. In the order, the Governor states that the provision of adequate health care is among the "most pressing domestic issues" for the country. She further states that providing health care in Alaska is complicated by the state's "unique demographic characteristics, including our small and geographically disbursed population." The Council is tasked with addressing these complexities by synthesizing and building upon past health care planning efforts in order to fulfill the following objectives:

> . . . develop a statewide plan to identify short-term and long-term strategies to effectively address the issues of access to, and cost and quality of, health care for Alaskans. The council's development of a health care action plan should serve to educate all Alaskans about the myriad of public policy choices regarding health care issues and should engage both governmental agencies and the private sector in finding solutions to these problems.[9]

On May 8, 2007, the Governor appointed fourteen Alaskans to serve on the Council. These members include health care providers; administrators of hospitals, nursing homes, tribal and community health organizations; and current and former policymakers including non-voting ex-officio members Senator Bettye Davis and Representative Peggy Wilson, the respective chairs of the Senate and House Health Education and Social Services Committees. The group, under the guidance of DHSS Commissioner Karleen Jackson, held a "health care conference" and a total of seven public meetings between June and December, 2007, to gather public testimony on health care access, cost, and quality, and to educate Alaskans on health care issues in the state. The meetings were held at various locations in Anchorage, and were available via streaming live video online.

The Council submitted its final report and recommendations to the Governor and the Legislature on December 23, 2007. The order establishing the Council directed that the report include the following:

> (1) a description of the current health care system in Alaska;

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[9] Many of the state's various health plans are available through the "publications" section of the website of the Department of Health and Social Services at the following URL: *http://www.hss.state.ak.us/commissioner/Healthplanning/publications/default.htm*.

(2) an inventory and analysis of all existing private and public health care plans, reports, and Initiatives in Alaska;

(3) short-term and long-term statewide strategic plans designed to improve health care access, cost, and quality within the next ten years; each strategy should

(A) include estimates of cost and potential funding sources;

(B) involve non-traditional stakeholders, including business, philanthropic, faith-based, and other community organizations; and

(C) promote integration across public and private health care delivery systems; and

(4) performance measures and accountability mechanisms to provide policy makers with tools to assess the success of the strategic plans over time.[10]

According to the Council's report, however, the short operational time frame did not allow the group to address the Governor's directive to present fiscal information to accompany each of the strategies outlined in the report. The Council further indicates that implementation plans were beyond the scope of its report, but that its recommendations nonetheless present a "real and actionable foundation" for meeting the long-term goals and strategic directions articulated in its report. The first of these recommendations, as listed in Appendix A of the final report, is to create an "ongoing and quasi-independent" Alaska Health Care Commission.[11]

ASSESSING OTHER STATES' HEALTH PLANNING PROCESSES

Due to the limited timeframe allowed for this request, we were unable to conduct an extensive assessment of other states' planning processes. Our research does indicate, however, that the success of a given planning process is ultimately determined largely by the success of the plan once implemented. That is, a plan may only be considered a success if it achieves the goals and outcome targets articulated by the plan. With that in mind, there are a number of organization that have sought to identify the important aspects of successful planning in cross-disciplinary, collaborative circumstances such as those necessarily encountered in large-scale public health planning. One such organization, the National Charrette Institute (NCI), has published a "best practices" report on collaborative, community-based planning.[12]

Additionally, the Turning Point Collaborative, of which Alaska is a member, has a number of publications that identify the efforts and successes of its member-states. We include two of these

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[10] Further information, including meeting schedules, minutes and presentations from the meetings, live web stream links, numerous links to online healthcare resources and reports, and general information about the Council is available online at *http://www.hss.state.ak.us/hspc/meetings.html*

[11] We include the Alaska Health Care Strategies Council, "Final Report: Summary and Recommendations," as Attachment C.

[12] The report and more information on planning processes are available on the NCI website at *http://www.charretteinstitute.org/resources/NCI_RWJF_Forum.html*. The National Charrette Institute describes itself as a nonprofit educational institution that teaches the transformative process of dynamic planning to create healthy community plans.

publications as Attachment D.[13] In addition, synopses of the experiences and successes of specific states' activities in various areas of public health planning are available through the search function of the Robert Wood Johnson Foundation website at *http://www.rwjf.org/*.

I hope you find this information to be useful. Please do not hesitate to contact us if you have questions or need additional information.

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[13] Specifically, we include "Transforming Public Health State by State" and "States of Change: Stories of Transformation in Public Health." Additional Turning Point publications, including recommended statutory changes, performance management, and social marketing, as they relate to public health, are available on the group's website at *http://www.turningpointprogram.org/Pages/archives.html#reports*.

Attachment A

Alaska Department of He. "h and Social Services, Division of Public Health, "Healthy Alaskans 2010," Volumes I & II, November 2005; online at *http://hss.state.ak.us/dph/targets/ha2010/default.htm*

Attachment B

Alaska Department of Health and Social Services, "Moving Forward: Comprehensive Integrated Mental Health Plan, 2006-2011;" available online at http://www.hss.state.ak.us/commissioner/healthplanning/movingforward/default.htm

Comprehensive Integrated Mental Health Plan: 2006-2011

WEBSITE UPDATE

2007

http://hss.state.ak.us/commissioner/healthplanning/movingforward

Index

Email: compMHplan@health.state.ak.us

Executive Summary

Moving Forward, Comprehensive Integrated Mental Health Plan 2006-2011 is the work of the Alaska Department of Health and Social Services, the Alaska Mental Health Trust Authority and other state agencies, boards and commissions. This plan is a response to a statutory requirement that such a plan be developed (AS 47.30.660).

The Comprehensive Integrated Mental Health Plan has a vision of optimal quality of life for Alaskans, especially those Alaskans who receive services under the Comprehensive Integrated Mental Health Program. By law, these recipients (also called beneficiaries) are Alaskans who have a mental illness, a developmental disability, experience chronic alcoholism, or suffer from Alzheimer's disease or a related dementia. Also included are individuals at risk of developing these conditions — for example, children who exhibit behaviors or symptoms suggesting they may develop a mental disorder.

The Comprehensive Integrated Mental Health Plan 2006-2011 looks at the status of Trust beneficiaries in four areas: health, safety, quality of life and economic security. Data are used to show long-term changes in these four areas. Another section of the Plan examines current service delivery and gaps in service. The Plan highlights current efforts to improve health, safety, living with dignity, and economic security for Trust beneficiaries and indicates future avenues for further efforts.

Abbreviations Used in this Plan

CIMHP	Comprehensive Integrated Mental Health Plan
DHSS	Alaska Department of Health and Social Services
AMHTA	Alaska Mental Health Trust Authority
AS	Alaska Statutes
AMHB	Alaska Mental Health Board
ABADA	Advisory Board on Alcoholism and Drug Abuse
ACoA	Alaska Commission on Aging
GCDSE	Governor's Council on Disabilities and Special Education

Figures and Tables Index

- Figure 12: SSI/APA Payment Compared to Alaska Poverty Level
- Figure 13: Population Age 18 and Over by Income Level and Disability Status, 2005-2006
- Figure 14: Number of Trust Beneficiaries Receiving Support through Division of Vocational Rehabilitation vs. Number Employed
- Figure ES-1: MR/DD* Waiver Recipients who Receive Supported Employment Services
- Figure ES-2: Average Number of Participants in Medicaid Buy-in Option
- Table E-1: Alaska Rent-Wage Disparities
- Figure 15: Components of Care for Three or More Beneficiary Groups
- Figure 16: *Bring the Kids Home* Results by State Fiscal Year - Percent of Alaska Children Receiving RPTC Services In-State and Out-of-State
- Figure WD-1: Behavioral Health Program Degrees and Certificates Awarded at Alaska's Universities
- Figure WD-2: University of Alaska Behavioral Health Program Enrollment
- Table 2: Current CIMHP Services Matrix
- Definitions for Levels of Community
- Continuum of Care Matrix for Alaskans with Mental Illness or Chronic Alcoholism
- Continuum of Care Matrix for Alaskans with Developmental Disabilities
- Continuum of Care Matrix for Alaskans with Alzheimer's Disease or Related Dementia

I. Introduction

Plan Vision

The vision of the Comprehensive Integrated Mental Health Plan is optimal quality of life for all Alaskans, especially those experiencing mental and emotional illness, cognitive and developmental disabilities, alcoholism and substance use disorders, and Alzheimer's disease or similar dementia.

Authority for Plan

Alaska Statute 47.30.660 requires the Department of Health and Social Services, in conjunction with the Alaska Mental Health Trust Authority, to develop and revise a plan for a comprehensive integrated mental health program for Alaska. Under the statute, the preparation of this plan is to be coordinated with federal, state, regional, local, and private entities involved in mental health services.

Purpose of Plan

The purpose of this Comprehensive Integrated Mental Health Plan (Comp MH Plan) is to guide resource allocation decisions in the development of services, workforce, and facilities to meet the needs of Trust beneficiaries. The overall goal is a service system that quickly meets the needs of each individual, where highly qualified staff from state, federal, tribal and private agencies have the resources necessary to work together to provide seamless care for the best outcome possible for each person. Another goal is to reduce the incidence of Trust beneficiaries' disabling conditions through prevention and early intervention, to the extent possible.

Moving Forward: Comprehensive Integrated Mental Health Plan is coordinated with plans developed by the Alaska Mental Health Board, the Governor's Council on Disabilities and Special Education, the Governor's Advisory Board on Alcoholism and Drug Abuse and the Alaska Commission on Aging, collectively called the beneficiary planning and advocacy boards, and by the Department of Corrections' 1999 plan. This plan is also linked with such DHSS plans as Healthy Alaskans 2010 and other planning initiatives. (hyperlink to http://hss.state.ak.us/commissioner/Healthplanning/publications/assets/stateHealthPlans.pdf

Target Population of Plan

Moving Forward: Comprehensive Integrated Mental Health Plan has a vision of optimal quality of life for Alaskans, especially those Alaskans who receive services under the Comprehensive Integrated Mental Health Program (AS 47.30). By law, these service recipients (also called Trust beneficiaries) are Alaskans who have a mental illness, a developmental disability, experience chronic alcoholism or Alzheimer's disease or a related dementia. Efforts include prevention, to the extent possible, of these disabling

conditions. Those who may need services in the future are included in this plan since prevention is the surest way to limit human suffering and is usually the least costly strategy.

Extent of the Problem

With Alaska data and national prevalence data, we can estimate that there are currently up to 90,000 Trust beneficiaries in Alaska. (This number may include duplications due to the nature of the data available). If those with substance use disorders were counted instead of just those who are alcohol dependent, the number of Trust beneficiaries would rise to 120,000.

- Chronic mental illness (adults): 27,600
- Serious Emotional Disturbance (youth): 17,000
- Alzheimer's Disease (adults over age 65): 4,900
- Brain injured: 10,000
- Developmentally disabled: 11,500
- Alcohol dependent: 19,000

Mental Illness:

Approximately 27,600 Alaskan adults experience chronic mental illness. These are adults who have a diagnosable mental disorder that has resulted in functional impairment which substantially interferes with or limits one or more major life activities such as the ability to perform self care, personal relations, living arrangements, or work.[1]

It is estimated that 17,000 young Alaskans (12 percent of the population under age 18) experience Serious Emotional Disturbance (SED). These are children and youth who have a diagnosable mental disorder that substantially interferes with or prevents them from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills such as completing their education.[2]

Alzheimer's Disease and Related Dementia:

An estimated one in eight Americans over age 65, and nearly half of those 85 or older, have Alzheimer's disease. From 2000 to 2004, deaths from Alzheimer's disease increased 33 percent, while deaths from heart disease, breast and prostate cancers and stroke declined.[3] Although Alzheimer's disease is not a normal part of aging, the risk of developing the illness rises with age.

Using national prevalence rates, the Alaska Commission on Aging estimates that as of 2006, there were 4,916 Alaskans aged 65 and above with Alzheimer's. As of January, 2007, 57 percent of residents in Alaska Pioneer Homes had a dementia diagnosis.[4]

It is estimated that one to four family members act as caregivers for each individual with Alzheimer's disease. Nearly 10 million Americans care for a person with Alzheimer's or other dementia, and about one-third of the caregivers are aged 60 and older.[5]

It is estimated that at least 10,000 Alaskans are living with brain injury today. Every year the Alaska Department of Health & Social Services reports about 800 traumatic brain injury (TBI) cases resulting in hospitalization or fatality. The Alaska TBI rate is 28 percent higher than the national average.[6]

Developmental Disabilities:

According to national prevalence data, 1.8 percent of the national population has a developmental disability. At this rate, it is estimated that 11,500 Alaskans have developmental disabilities.[7]

According to the U.S. Department of Education and other agencies, autism is the fastest-growing developmental disability. It is the most common of the Pervasive Developmental Disorders, affecting an estimated one in 150 births.[8] From 1993 to 2004, autism cases in ages 6-22 increased 522 percent nationwide and 685 percent in Alaska.[9]

Chronic Alcoholism:

Rates of heavy and binge drinking are consistently higher in Alaska than in the United States as a whole. In 2006, the highest prevalence of heavy and binge drinking was among young adults aged 25 to 34.[10]

In 2005, approximately 19,000 Alaskans were alcohol dependent and 49,000 had substance use disorders. Almost 27% of young Alaskans between the ages of 12 and 17 used alcohol in the last month, according to 2004 and 2005 statistics.[11] This is a significant concern, because research shows that young people who begin drinking before the age of 15 are four times more likely to develop dependence.[12]

II. Results Areas

Health

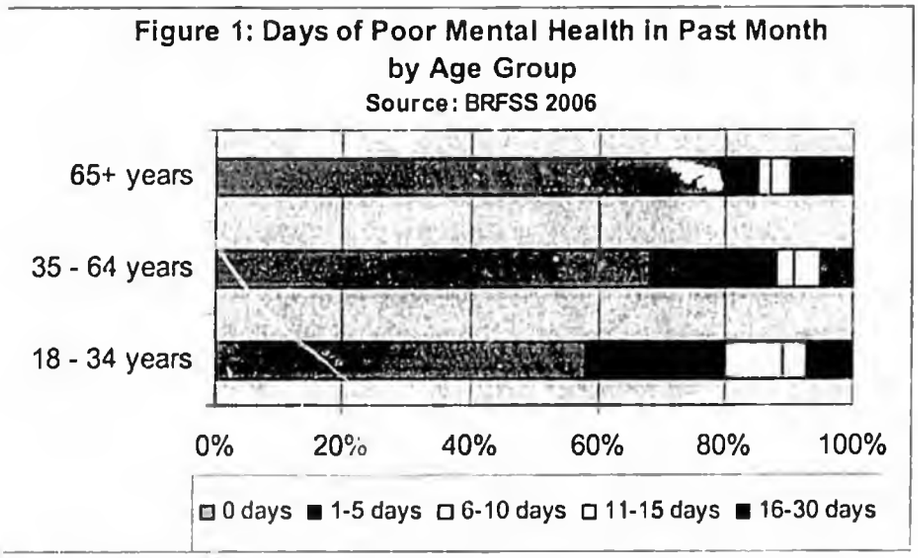
When someone is born as or becomes a Trust beneficiary, the individual and the family want the best care possible—the most helpful services close to home. Accessing behavioral health care can be difficult for Alaskans in small communities, for those who have inadequate or no health insurance, or whose access to information is limited. Not all communities, even larger ones, have a range of treatment programs and other needed supportive services. Without strong support and treatment services, people may not get the services they need, may become homeless, or become involved with the justice system.

Health Goal #1: Enhance quality of life through appropriate services for people with mental and cognitive disabilities and substance use disorders

Good physical and mental health is a common measure of an individual's well being. One way to assess a population's overall health is with a set of measures known as "Healthy Days."[13] Developed by the National Center for Disease Control, Healthy Days is one of the few population-based surveys of mental health status. It measures individuals' self-evaluation of their physical and mental health within the past 30 days.

Figure 1 — Days of Poor Mental Health in Past Month by Age Group

Data from the Behavioral Risk Factor Surveillance Survey[9] show the percent of Alaskans surveyed who self-report the number of days in the prior month that they experienced "poor mental health." Fourteen percent of survey respondents reported more than five days of poor mental health during the previous month. The percentage of young adults who report that they experienced between six and 10 days of poor mental health was three times higher than other age groups.

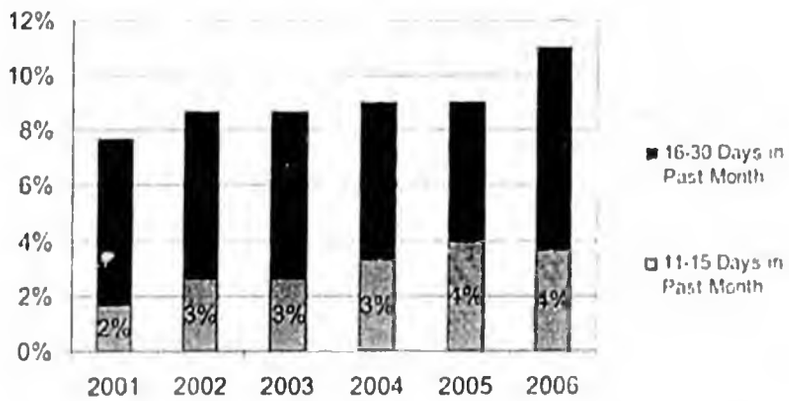


AK DHSS Division of Public Health, Behavioral Risk Factor Surveillance System

Figure HM-1 - Percent of Alaskans Reporting 11-15 Days and 16-30 Days of Poor Mental Health in Past Month, 2001-2006

The number of Alaskans in all age groups reporting poor mental health for more than half of the past month increased in 2006. The number reporting only 11 to 15 days of poor mental health in the past month has increased gradually during the last six years.

Figure HM-1
Percent of Alaskans Reporting 11-15 Days and 16-30 Days of Poor Mental Health in Past Month, 2001-2006



AK DHSS Division of Public Health, Behavioral Risk Factor Surveillance System

Health Goal #2: Reduce the abusive use of alcohol and other drugs to protect Alaskans' health, safety, and quality of life.

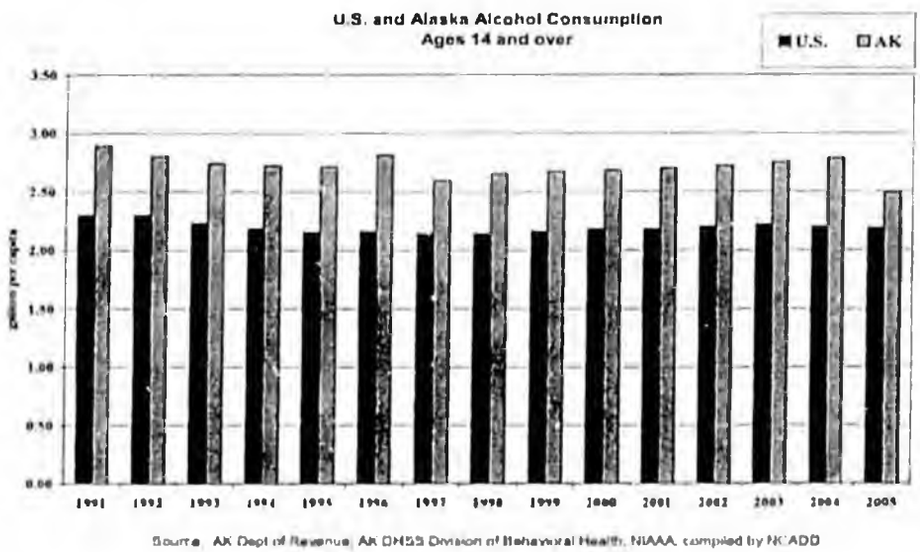
Alcoholism and chemical dependency have long been recognized as Alaska's number one behavioral health problem. Alcoholism and other addictive diseases not only compromise individuals' health but also create profound social problems. The social cost of alcohol abuse is seen in rates of related injuries, chronic disease, and deaths. National research shows that substance abuse has been implicated in 70 percent of all cases of child abuse and that 80 percent of the men and women behind bars are there because of drug or alcohol related crime.[14]

Figure 2 — U.S. and Alaska Alcohol Consumption Comparisons

Alcohol consumption rates reflect the prevalence and severity of alcohol related problems. The alcohol consumption rate in Alaska has been higher than the rate in the rest of the nation during each of the last 14 years, and is well above the *Healthy Alaskans 2010* goal of 2.2 gallons or less per person per year.

Data from the National Institute on Alcohol Abuse and Alcoholism (NIAAA) indicates that Alaska remains in the highest group for alcohol consumption in the nation (per capita ethanol consumption per 10,000 people aged 14 and over). Consumption rates are calculated with in-state sales of alcoholic beverages and the state population of persons 14 years and older.

Figure 2

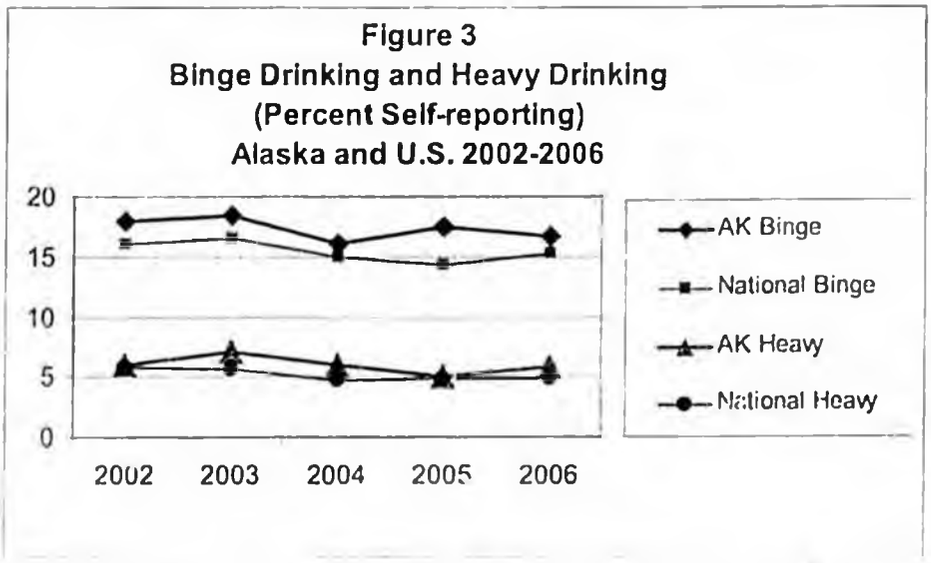


Source: AK Dept of Revenue, AK DHSS Division of Behavioral Health, NIAAA, compiled by NCADD

Figure 3 — Heavy and Binge Drinkers, Alaska and U.S.

Another indication of the pervasiveness of alcohol abuse is the percentage of Alaskans who report acute (binge) and chronic (heavy) drinking. The Behavioral Risk Factor

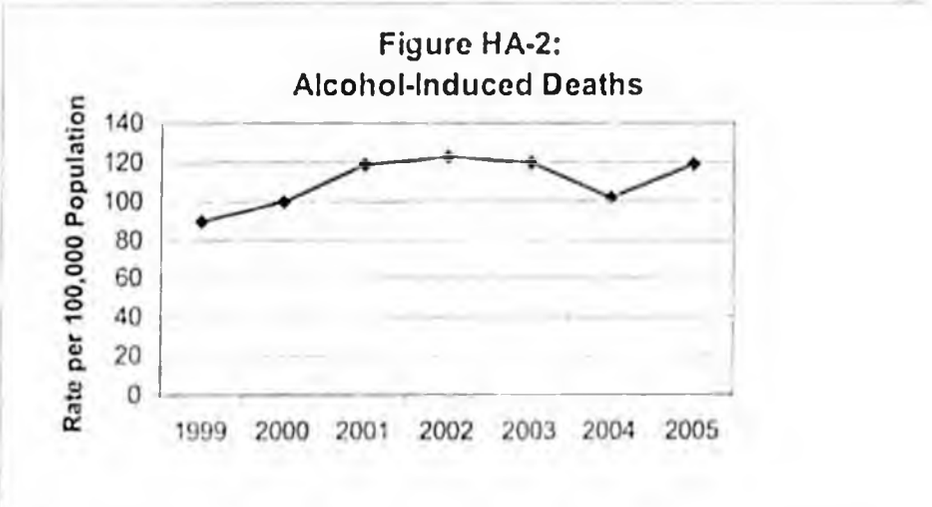
Surveillance Survey[9] shows that binge drinking is more prevalent than heavy drinking, and each year Alaskan adults report more binge and heavy drinking than in the rest of United States. In 2006, the highest prevalence of binge (31%) and heavy (7 %) drinking in Alaska was among young adults aged 18 to 24. Overall, heavy drinking in Alaska rose slightly between 2005 and 2006.



AK DHSS Division of Public Health, Behavioral Risk Factor Surveillance System

Figure HA-2 — Alcohol Induced Deaths

Data for alcohol-induced deaths includes fatalities from alcoholic psychoses, alcohol dependence syndrome, non-dependent abuse of alcohol, alcohol-induced chronic liver disease and cirrhosis, and alcohol poisoning. It does not include deaths due to traumatic injury, such as motor vehicle crashes. There were 119 alcohol-induced deaths in Alaska in 2005.



Source: DHSS Division of Public Health, Bureau of Vital Statistics

On average, 16.7 years of productive life were lost for each alcohol-induced death. The rate of alcohol-induced deaths for Natives was nearly six times higher than that for whites. Alaska males were over 25 percent more likely than females to die from alcohol-induced causes, but this disparity is less than in the U.S. as a whole.[15]

Health Goal #3: Promote healthy births and encourage early childhood interventions to reduce the risk of disability

Alaska families, like those everywhere, strive to have healthy babies and provide good homes for their children. The first three years of a child's life are a time of extraordinary growth physically, mentally, emotionally, and socially. We know that environmental factors have a profound influence on the brain. Research confirms that many children's mental health problems are related to family violence, parents' chemical addiction, mental illness, and poverty.[16] Often a number of identifiable stresses combine to create family dysfunction and to compromise the children's development and health.

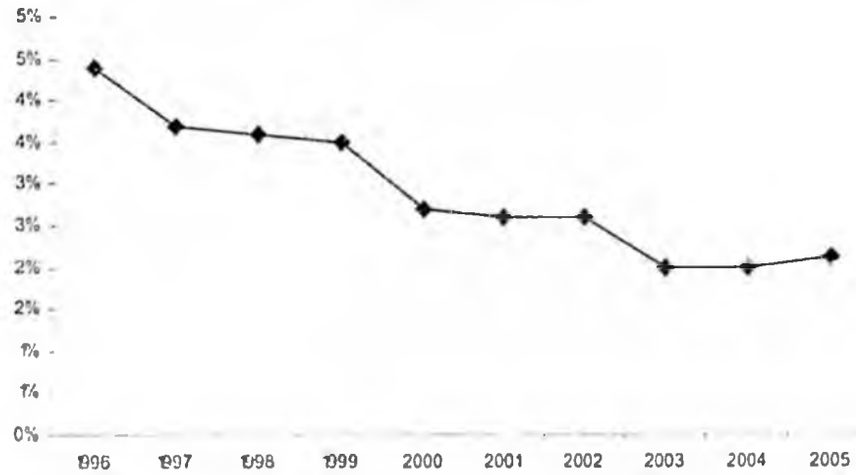
Figure 4 — Percentage of Women Self-reporting Alcohol Consumption During Pregnancy, Alaska 1996-2005

The U.S. Substance Abuse and Mental Health Services Administration estimates the prevalence of FASD at about 100 per 10,000 live births. Brain damage can occur when alcohol crosses the placenta and damages developing tissues. The result may be mild to severe cognitive impairment, mental retardation, social and emotional problems, learning disabilities, visual impairment, neurobehavioral problems and other structural birth defects.. Approximately 126 infants are born each year in Alaska who have been affected by maternal alcohol use during pregnancy.[17]

Alaska Bureau of Vital Statistics birth data indicates an overall decrease in self-reported alcohol use during pregnancy between 1996 and 2005 and a slight increase from 2004 to 2005 (Figure 4). It is generally acknowledged that this data, self-reported by women at the time of delivery, is underreported. However, it is agreed that over the last decade, there has been a significant decline in prenatal alcohol use in Alaska.[18]

For more information about efforts to prevent FASD, see Initiatives section.

Figure 4: Percentage of Women Self-reporting Alcohol Consumption During Pregnancy Alaska 1996-2005



Source: DHSS Div of Public Health, Vital Statistics

Health Goal #4: Reduce the number of suicides in Alaska.

In 2004, the latest year for which official data are available nationally, Alaska's suicide rate was the highest in the nation. Alaskans aged 20-29 years had the highest rate, followed by the 30-39 year old group. The estimated years of potential life lost due to suicide in Alaska was 4,686.[19]

Figure 5 — Alaska Suicide Rates per 100,000 Population by Area, Alaska 1996-2005

Figure 5 shows Alaska's age-adjusted suicide rates per region for the years 1996 through 2005. The regions with the lowest rates of suicide were Kodiak and the Aleutians, while the highest rates were in Nome and the Northwest Arctic.

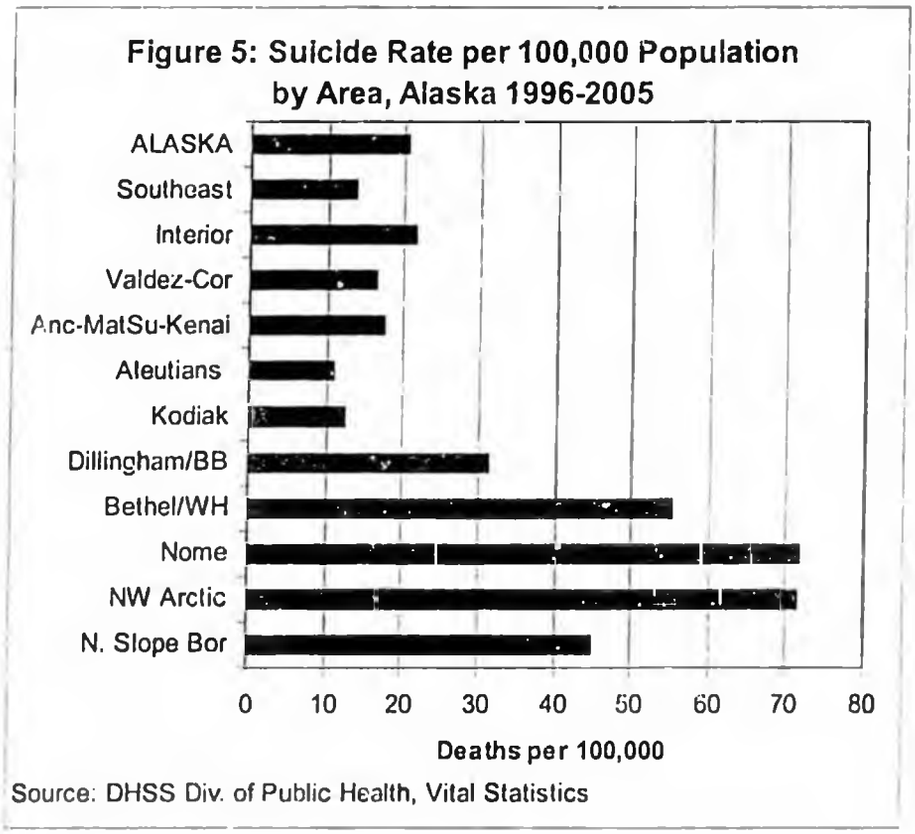
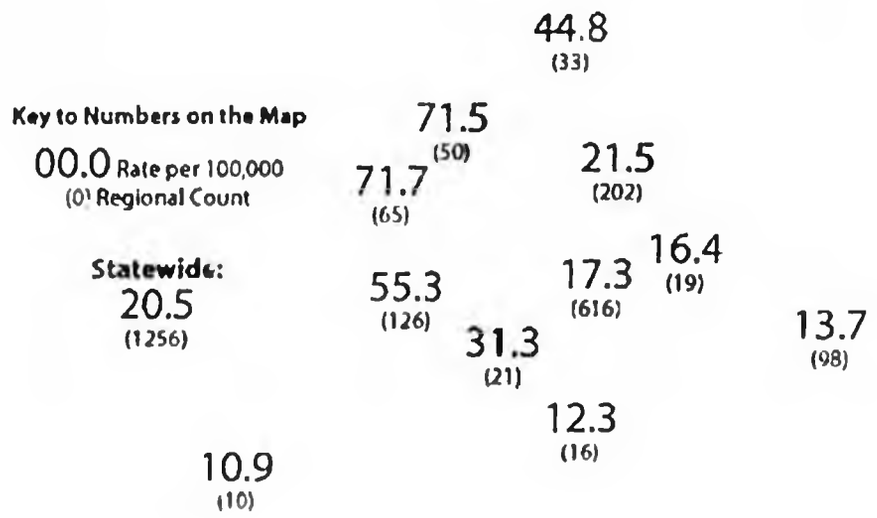


Figure 6: Alaska Suicide Rates (and Numbers) by Region, 1996-2005



Source: DHSS Div. of Public Health, Vital Statistics, compiled by Health Planning and Systems Development

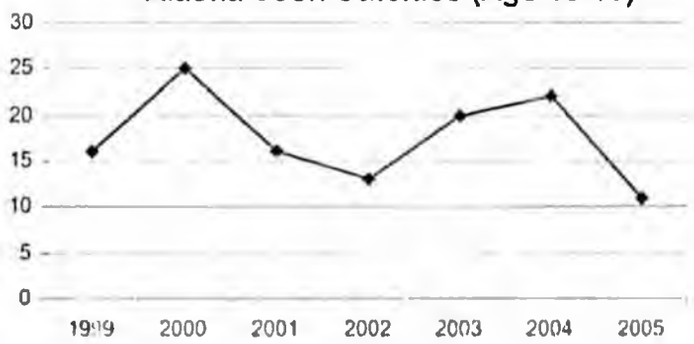
The *Alaska Suicide Follow-back Study* contains information from interviews with the families of some of Alaska's suicide victims from 2003 to 2006. According to the interviews, more than half (54%) of the decedents had a disability or illness that made it difficult for them to take care of normal daily activities. Almost two-thirds (62%) of decedents were reported to have had current prescriptions for mental health medications at the time of their death but many were not taking the medications as prescribed.[20]

Among the suicide cases that had a follow-back interview, a binge drinking rate of 43 percent was reported, which is 2.5 times higher than the Alaska rate and three times higher than the national estimated rate according to the 2005 BRFSS. 43percent of the interviewees said the decedents drank alcohol daily. The interviews indicated that 54 percent of the decedents had smoked marijuana within the past year. The reported rate for alcohol and drug use by Alaska Natives was exactly the same as for non-Natives. Although Alaska Natives comprise only 16 percent of the population, they accounted for 39 percent of the suicides.[21]

Figure HS-1 — Alaska Teen Suicides

Among Alaskans aged 15 to 19, there were 22 suicides in 2004 and 11 in 2005.

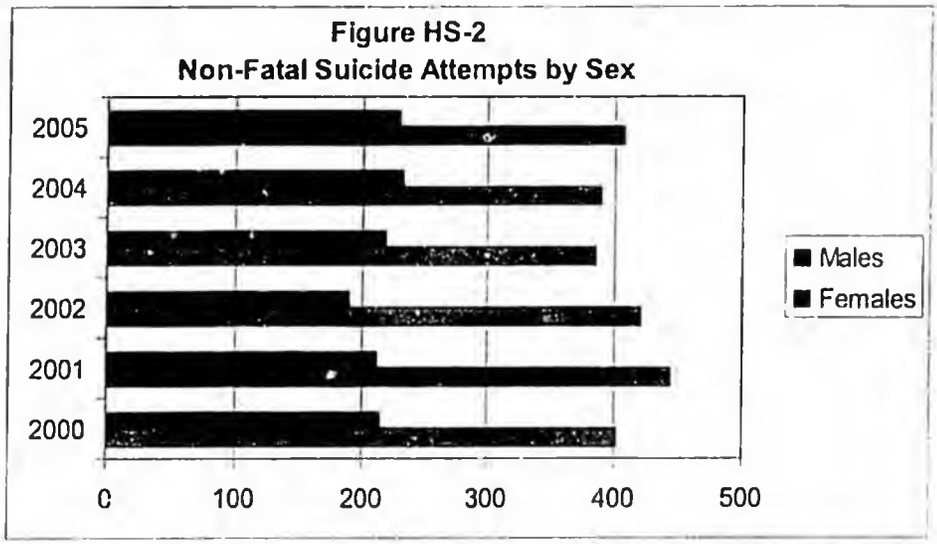
Figure HS-1
Alaska Teen Suicides (Age 15-19)



Source: DHSS Division of Public Health, Bureau of Vital Statistics, Health Profiles

Figure HS-2 — Non-fatal Suicide Attempts by Sex

Between 2000 and 2005, non-fatal suicide attempts were almost twice as high among Alaskan women as compared to men.



Source: Alaska Trauma Registry, 2000-2005, Alaska residents (hospital admissions of 24 hours or more); DHSS DPH Section of Injury Prevention and EMS staff.

Suicidal ideation/attempts from 2003 Youth Risk Behavior Survey (YRBS[22])

- Percentage of students who actually attempted suicide one or more times during the past 12 months: 8.1 %
- Percentage of students who seriously considered attempting suicide during the past 12 months: 16.7 %

Protective Factors

Measures that enhance resilience or protective factors are as essential as risk reduction in preventing suicide. Positive resistance to suicide is not permanent, so programs that support and maintain protection against suicide need to be ongoing.

Protective factors include:

- Effective and appropriate clinical care for mental, physical, and substance abuse disorders
- Easy access to a variety of clinical interventions and support for help seeking
- Restricted access to highly lethal methods of suicide
- Family and community support
- Support from ongoing medical and mental health care relationships
- Learned skills in problem solving, conflict resolution, and nonviolent handling of disputes
- Cultural and religious beliefs that discourage suicide and support self-preservation instincts[23]

The Current Initiatives section reflects projects to prevent suicide in Alaska.

Health Goal #5: Access: ensure high quality treatment, recovery and support services are provided as close to one's home community as possible.

The Department and The Trust aim to provide sustainable, comprehensive behavioral health services that are based in local communities so that residents can be served as close to their home as possible. Some of the current initiatives that address this goal are the Bring the Kids Home Initiative, the Community-based Suicide Prevention and Rural Human Services project, the Comprehensive Fetal Alcohol Syndrome Project, and Workforce Development.

Estimated Number of Alaska Mental Health Trust Beneficiaries Served by DHSS Divisions (Figure HC-1)

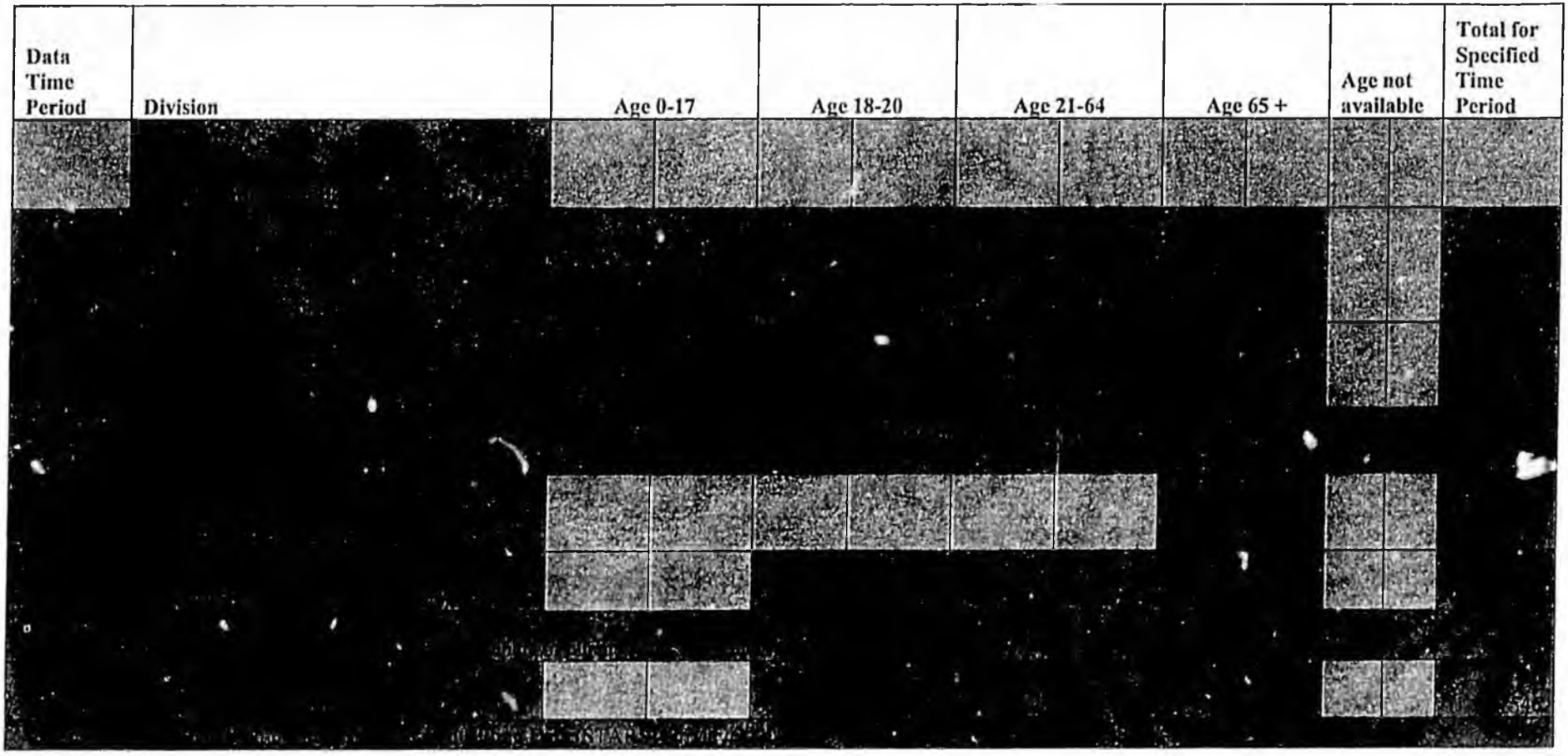
The Department of Health and Social Services serves many Trust beneficiaries in its various programs throughout the state. An estimate of the number of Trust beneficiaries served by each division within the Department is shown in Figure HC-1. Since people served remain anonymous, and the same person may have been served by more than one program or division during the same year, there is not a way to avoid duplication in the numbers in all divisions.

Figure HC-1

Estimated Number* of Alaska Mental Health Trust Beneficiaries Served by DHSS Divisions
***Actual number may be lower - there is duplication in some of the data reported.**

Data Time Period	Division	Age 0-17		Age 18-20		Age 21-64		Age 65 +		Age not available		Total for Specified Time Period
		Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	
FY 2005	Behavioral Health (DBH) - Mental health	3397	4271	247	243	2614	1782	69	29	3	5	12,660
Source:	*These are state community mental health settings, state psych hospitals, and other settings. Some clients may have been served in more than one setting so would be counted twice.* Source: CMHS FY 2005 Uniform Reporting System, Basic Table 3A and B.											
April - Dec., 2005	DBH - FASD Diagnostic team	91		8								99
Source:	*This is the number of clients referred to and screened by the FASD Multidisciplinary Community Diagnostic Teams between April and December 2005. Of those screened, 3% were diagnosed with FAS or atypical FAS; 51% with static encephalopathy; 39% with neurobehavioral disorder; and 7% were found to have no evidence of organic brain damage.* Source: Behavioral Health Research & Services FAS Evaluation Summary Report of the Alaska Multidisciplinary FASD Diagnostic Team Data, UAA (DHRS FAS-Related Technical Report No. 35)											
FY 2005	DBH - Chronic Alcoholism			776								776
Source:	*Estimates drawn from State grantee residential substance abuse treatment facilities quarterly reports to DBH. Excluded from these numbers are youth and women with children.*											

Data Time Period	Division	Age 0-17	Age 18-20	Age 21-64	Age 65 +	Age not available	Total for Specified Time Period
1/1/07 to 4/30/07	Juvenile Justice (DJJ) - Age 0-21						841
	Female	142					
	Male	699					
	Numbers represent youth on supervision with DJJ who had at least one Axis 1 diagnosis, under DSM-IV-TR (clinical disorders & other conditions that may be a focus of clinical attention). Most were 17 years of age or younger. Of the total, 39% also had a co-occurring disorder (substance related disorder accompied by a mental health disorder). Alaska Native youth had more Axis 1 primary diagnoses than any other group. Source: *DHSS Div. of Juvenile Justice*						
One-day snapshot, 5/1/07	**Pioneer Homes**				263		263
Source:	*Total Pioneer Home residents with a dementia diagnosis (sorted for "dementia" in ICD-9 code).* Source: *Division of Pioneer Homes, Accu-Med Electronic Medical Records System*						
One month - April, 2007	**Public Assistance (DPA)** -Alaska Temporary Assistance Program (ATAP) (4/05)	3381					4,784
April, 2007	DPA- Adult Public Assistance (APA)	16,568					16,104
April, 2007	DPA - Food Stamps	22,491					21,477
Source:	*These figures reflect a one-month caseload for all Alaskans; this data does not break out the number of Trust beneficiaries. Not counted are the customers whose cases are managed by the tribal system.* Source: *DPA*						


Data Time Period
Division
Age 0-17
Age 18-20
Age 21-64
Age 65 +
Age not available
Total for Specified Time Period

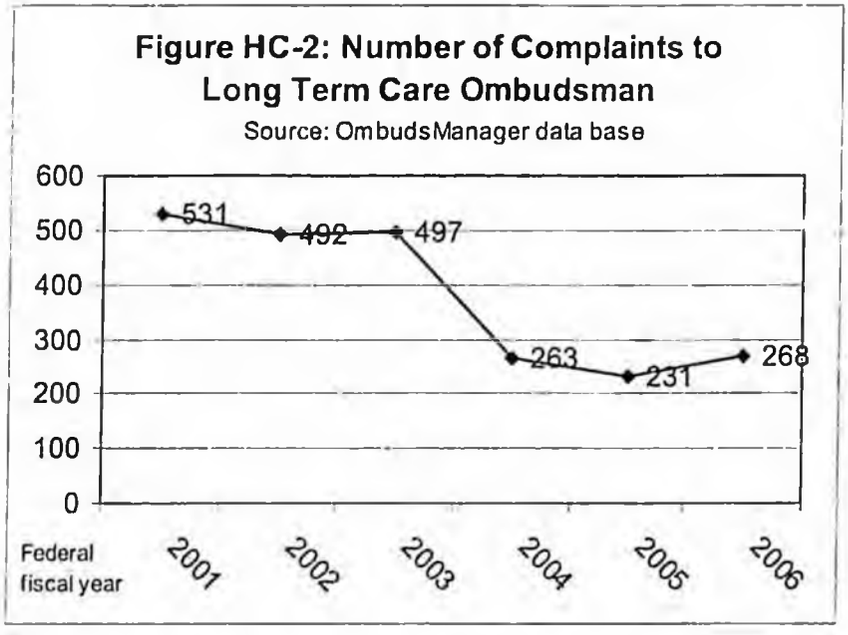
Public perceptions of care

The public behavioral health system is responsible for providing safe and effective care. The system has changed with consumers' increasing involvement in choosing the types of treatment and other services they receive. Today, many agencies include consumers on their boards of directors. Consumers participate in quality assurance reviews for mental health, developmental disabilities, and early intervention/infant learning programs. Consumer satisfaction surveys are included in most provider reviews conducted by the Department of Health and Social Services.

Public perceptions of care as indicated through number of complaints to the Long-Term Care Ombudsman (Figure HC-2).

In 1978, the federal Older Americans Act began requiring every state to have a Long Term Care Ombudsman Program to identify, investigate and resolve complaints and advocate for seniors. The ombudsman investigates complaints about nursing homes, assisted living homes, and senior housing units as well as concerns about individuals' care and circumstances. Consumers, family members, administrators, and facility staff can make complaints regarding the health, safety, welfare, or rights of a long-term care resident. The Alaska ombudsman's office is administratively managed by and resides in the office of the Alaska Mental Health Trust Authority. The majority of funding for the office comes from grants through the federal Administration on Aging.

Figure HC-2 shows the number of complaints that Alaska's Office of the Long-Term Care Ombudsman received from consumers each year. Most of the complaints were against assisted living homes and nursing homes. Beginning with fiscal year 2004, fewer complaints were recorded in this data base because at that time they began counting only cases that their office was actively investigating. Before 2004 the cases they counted also included ones that they were monitoring and that were being investigated by other state agencies such as Adult Protective Services and Certification and Licensing. There have been about 250 complaints actively investigated during each of the last three years.



Alaska has one of the fastest-growing senior populations of all the states, with the number of seniors expected to more than double by 2030. While Alaska seniors have a higher mean and median income than U.S. seniors as a whole, higher living costs may consume much of that additional income. Incomes of senior households located in rural areas and those headed by Alaska Natives have substantially lower incomes. The poorest group is seniors age 85 and over, which is also the fastest-growing sub-group of the senior population. By 2030, the number of Alaskans in this age group is expected to triple. [23]

Consumers Satisfied with Public Mental Health and Substance Abuse Services (Figures HC-3a and HC-3b).

Figures HC-3a and b show the results of a cooperative effort between the DHSS Division of Behavioral health and providers to ask consumers to evaluate services. Questions were asked about satisfaction with services, quality and outcomes, participation in treatment outcomes, access to services, and cultural sensitivity. For interviews in fiscal year 2006, satisfaction ranged from 70 to 82 percent.

Figure HC-3a - Adults

Consumers Satisfied with Public Mental Health and Substance Abuse Services

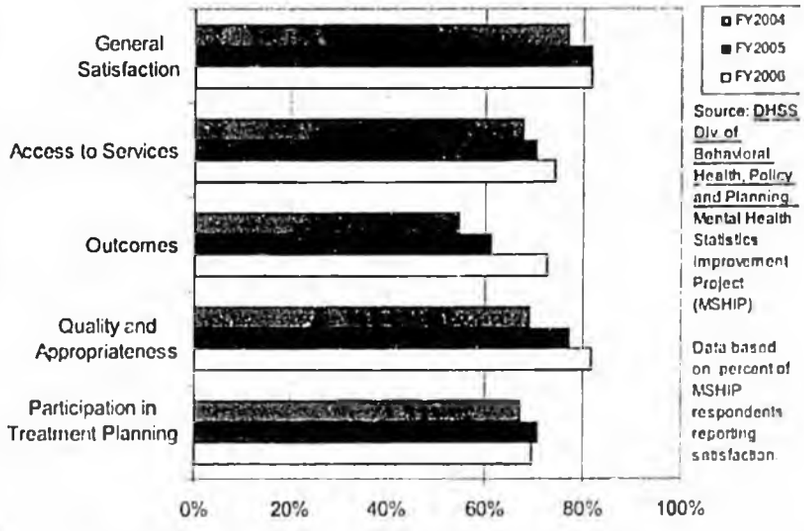
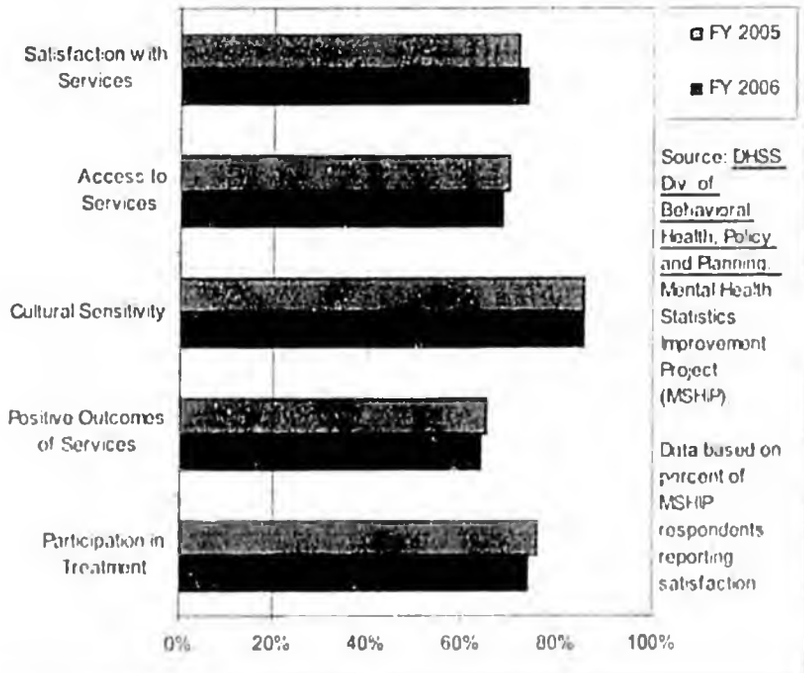


Figure HC-3b - Youth / Families with Youth

Consumers Satisfied with Public Mental Health and Substance Abuse Services



Public perceptions of care as indicated through agencies with family members or consumers on governing/advisory boards

A majority of the behavioral health and developmental disability agencies now include consumers on their governing boards. All 84 agencies providing behavioral health services met the review standard of having consumers or family members in sufficient numbers on the agency governing body or board to ensure their meaningful participation. Consumers of publicly funded behavioral health and developmental disabilities services demand increased involvement in their treatment and care. Consumers or family members of consumers also sit on each of the four statewide advocacy boards and commission.

Safety

Thousands of Alaskans with mental and developmental disabilities are incarcerated each year because they do not get the services they need through Alaska's treatment and support systems. Police and court responses are often the only available resolution to crises or to public displays of untreated mental health problems, when appropriate treatment to prevent or respond to these situations was either unavailable or inaccessible.

Alaska has a high rate of child abuse and domestic violence. Experiencing or even witnessing violence may result in developmental delays, emotional disorders and substance use disorder.[24] Adults with cognitive or developmental disabilities are also vulnerable to neglect and abuse. State programs can assist in strengthening and re-building families, providing treatment, and providing guardianship for adults with mental impairments.

Filling the gaps in treatment and support services, both in communities and within the correctional system, can prevent crises that bring people with mental and developmental disabilities into contact with the criminal justice system and contribute to their repeated incarceration. Training for police, court and prison personnel can help divert many people into appropriate treatment in communities or provide effective treatment when people with mental health problems or developmental disabilities are unavoidably or necessarily incarcerated.

Safety Goal #1: Protect children and vulnerable adults from abuse, neglect, and exploitation

Childhood maltreatment has been linked to a variety of changes in brain structure and function and stress-responsive neurobiological systems.[25] The Adverse Childhood Experiences (ACE) Study provided evidence that adverse childhood experiences cast a major shadow on health and well-being in peoples' lives even 50 years later. "Adverse childhood experiences" include repeated physical abuse; chronic emotional abuse; and growing up in a household where someone was alcoholic or a drug user; a member was imprisoned; a mother was treated violently; someone was mentally ill, chronically depressed, or suicidal; or parents were separated or divorced during childhood.[26]

Figure WS-1 — Unduplicated Count of Children with Reports of Harm

Figure WS-1 shows the unduplicated count of Alaska's children for whom a report of harm was received by the Alaska Department of Health and Social Services Office of Children's Services. Each child is counted only once regardless of the number of reports received. Generally, it indicates the number of children for whom individuals reported some safety concerns to the Office of Children's Services. OCS did not investigate all reports of harm received; some did not meet OCS criteria for investigation and some were referred for another type of response. The number of children with reports of harm increased from 9,531 in state fiscal year 2004 to 12,491 in state fiscal year 2006.

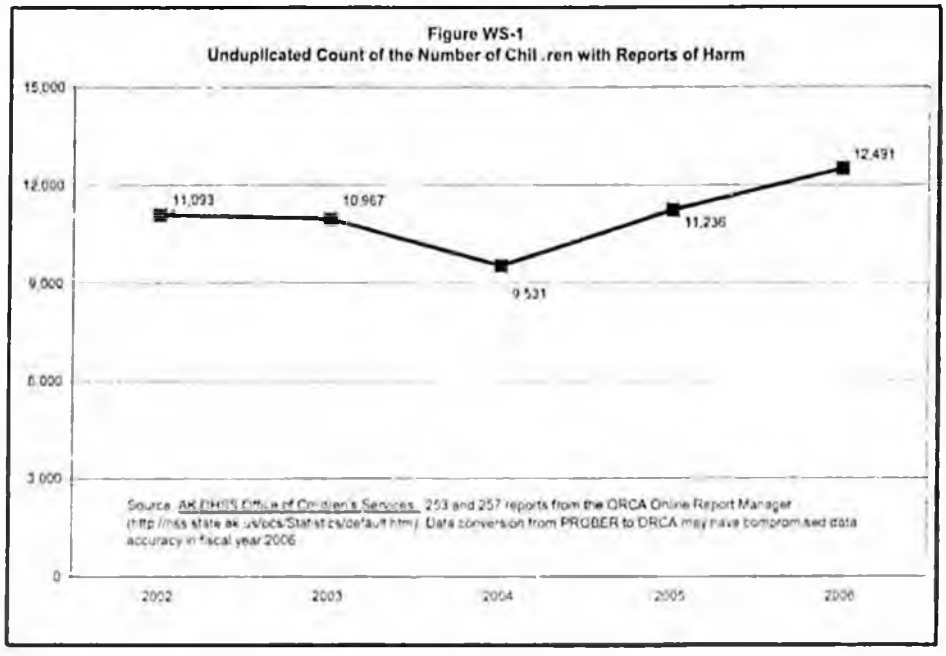


Figure 7 — Safety of Children: Number of Children with a Substantiated Report of Harm by Type of Harm

Figure 7 represents the number of Alaska's children who were substantiated as victims of child abuse and neglect. It counts children who had a report of harm which was investigated and harm substantiated. Each child is counted once for each type of harm substantiated. Types of harm reported and substantiated include neglect, physical abuse, sexual abuse, mental injury, and abandonment. The number of substantiated reports of harm increased between state fiscal year 2005 and state fiscal year 2006.

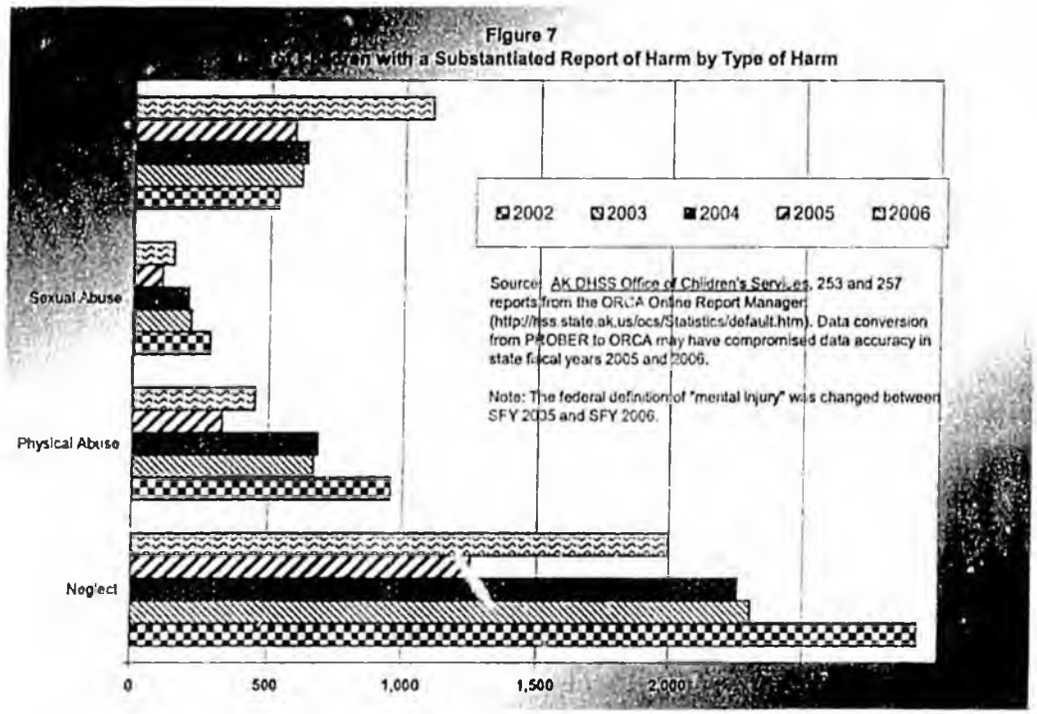
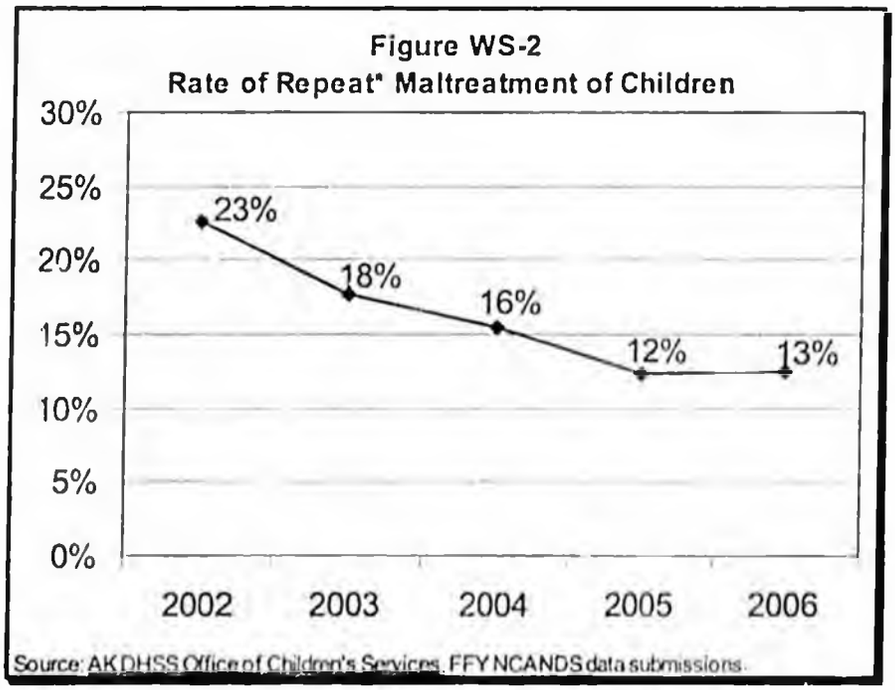


Figure WS-2 Rate of Repeat Maltreatment of Children

Figure WS-2 shows the percentage of all children who were subjects of substantiated or unconfirmed reports of harm during the first 6 months of the year and who had another substantiated or unconfirmed report of harm within 6 months. In state fiscal year 2006, the rate of repeat maltreatment was 13 percent.



Reports of physical injury, sexual assault, and threats/injuries by weapon at school from Youth Risk Behavior Survey [22]

According to the Youth Risk Behavior Survey, the number of high school students reporting threats and sexual abuse has increased since 2003.

- **2003 Youth Risk Behavior Survey**
    - 4.1 percent of students did not go to school on one or more of the past 30 days because they felt unsafe at school or on their way to or from school.
    - 8.1 percent of students have been physically forced to have sexual intercourse when they did not want to

- **2007 Youth Risk Behavior Survey**
    - 5.5 percent of students did not go to school on one or more of the past 30 days because they felt unsafe at school or on their way to or from school.
    - 9.2 percent of students have been physically forced to have sexual intercourse when they did not want to

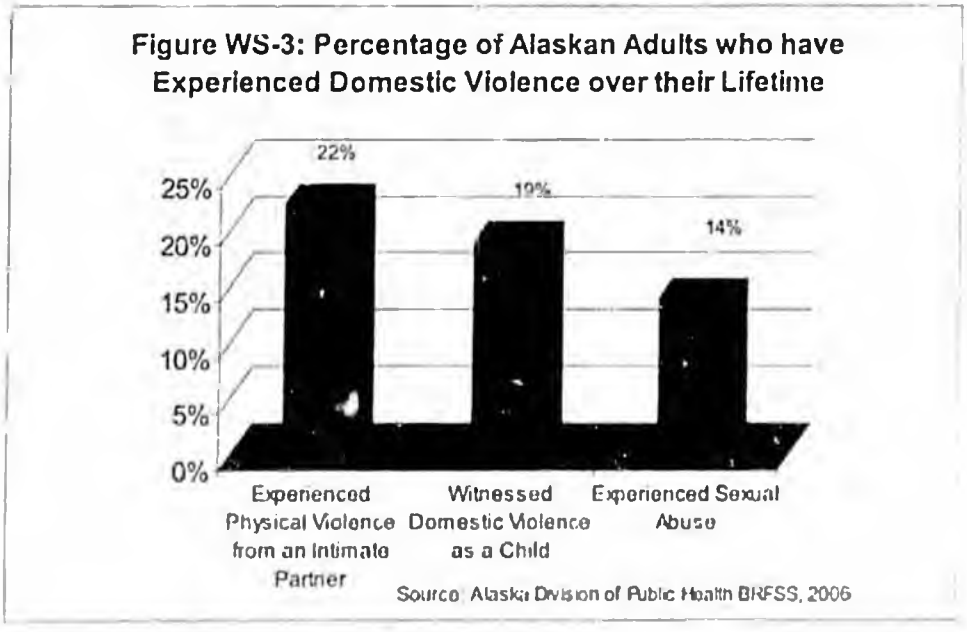
Table S-1: Domestic Violence and Sexual Assault Fiscal Year 2006 Statistics

During fiscal year 2006, Alaska shelters provided services to 8,140 clients. 25% of the clients were children. Services include safe shelter, crisis intervention, food and clothing, referrals and many other services. Table S-1 aggregates the field reports from victim service providers and shows the types of incidents experienced by the clients. The top three types of incidents were domestic violence, sexual abuse of children, and sexual assault toward adults.

Adult Molested as a Child Count	59
Assault Count	195
Child Physical Abuse Count	109
Child Sexual Abuse Count	898
Domestic Violence Count	5,257
DWI / DUI Victim Count	14
Elder Abuse (victim 60+ years of age) Count	11
Other Violent Crime Count	79
Robbery Count	13
Sexual Assault (adult) Count	653
Stalking Count	139
Survivor of Homicide Victim Count	37
Grand Count	7,464

Figure WS-3: Percentage of Alaskan Adults who have Experienced Domestic Violence over their Lifetime

Figure WS-3 shows the percentage of participants in the most recently-available Behavioral Risk Factor Surveillance Survey (BRFSS)[14] who responded that they had witnessed domestic violence in their family as a child, experienced physical violence from an intimate partner, or been sexually abused during their lifetime. In 2006, twenty-two percent of Alaskan adults had experience physical violence from an intimate partner; fourteen percent had witnessed domestic violence as a child; and fourteen percent had experienced sexual abuse.



Adult Protective Services Reports of Harm

Alaska law defines vulnerable adults as persons 18 years of age or older who, because of a physical or mental impairment or condition, are unable to meet their own needs or to seek help without assistance.[27] Adult Protective Services in the Department of Health and Social Services receives and investigates reports of harm. Harm includes abandonment, abuse, exploitation, and neglect (the most common report). More than half of the clients are female.

Adult Protective Services Investigations:

Total investigations FY 04: 1173
Total investigations FY 05: 1497
Total investigations FY 06: 1427[28]

In fiscal year 2006, the Department of Health and Social Services was contacted about 1666 people (unduplicated) for whom an investigation was possibly warranted; 86% of these intakes were investigated.

Safety Goal #2: Prevent and reduce inappropriate or avoidable arrest, prosecution, incarceration and recidivism of persons with mental health problems or developmental disabilities through appropriate treatment and supports.

Jail Diversion — Arrest History:

The Alaska Mental Health Board, the Alaska Mental Health Trust Authority, the Department of Corrections, the Court System, prosecutors, defense attorneys and community treatment providers have collaborated to implement Jail Alternative Services (JAS) and a therapeutic mental health court. JAS diverts voluntary low risk offenders to treatment instead of jail and monitors compliance with treatment.

The JAS program annually refers up to 40 eligible individuals to community treatment providers and monitors compliance with court-ordered treatment conditions. JAS is operated by the Department of Corrections for individuals sentenced through the Anchorage District Court Coordinated Resources Project "CRP" (Mental Health Court) to the JAS program.

Between July, 1998 and June, 2003, the JAS program served a total of 103 unduplicated clients. Of the 103 clients, 36 completed the program, 37 were vacated or opted out of the program after entry, and 30 were still active on the caseload. , These 103 clients had had a total of 197 misdemeanor arrests and 20 felony arrests during the 12 months prior to participation in Jail Alternative Service. During participation in JAS, arrests decreased sharply to 86 misdemeanor arrests and two felony arrests. In terms of total days of incarceration, there was a reduction of 4,468 inmate days related to JAS clients between the 12-month period before entry into JAS and the period while active in JAS — more than 12 years.

Once clients are no longer active in JAS, whether or not they have completed the program, there is no longer any legal leverage to require them to receive services. A measure of the effectiveness of the JAS program, therefore, is the extent to which these clients are able to maintain the gains that were so evident while active in JAS. Table 1 clearly shows that clients who successfully complete the JAS program fare considerably better after leaving JAS than those who do not complete the program.

Table 1 and Figures 8A and 8B show a reduction in legal recidivism as a result of the JAS program.

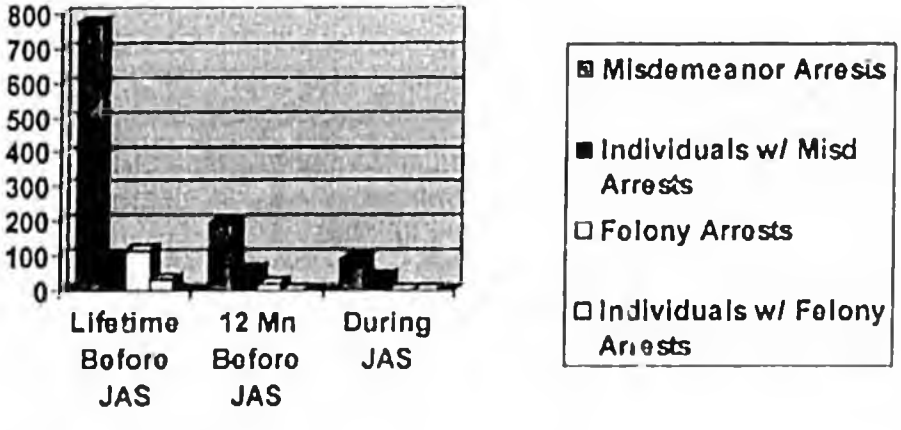
Table 1: Arrest Data for Clients not active in Jail Alternative Service (JAS)

Metric N=103	Lifetime Total Before JAS	12 Months Before JAS	During JAS
# Misdemeanor Arrests (New Charges)	773	197	86
# Individuals with Misd meanor Arrests	(100%) 103	(55%) 57	(45.2%) 40
# Felony Arrests	113	20	2
# Individuals with Felony Arrests	(29.1%) 30		2
Average Number of Arrests/per JAS Participant		2.1	0.9
Total Days in Custody for All JAS Participants	42,720	7,732	3,264

The length of time for JAS client participation ranged from 14 days to 1,742. The median length of time under JAS supervision was 402 days.

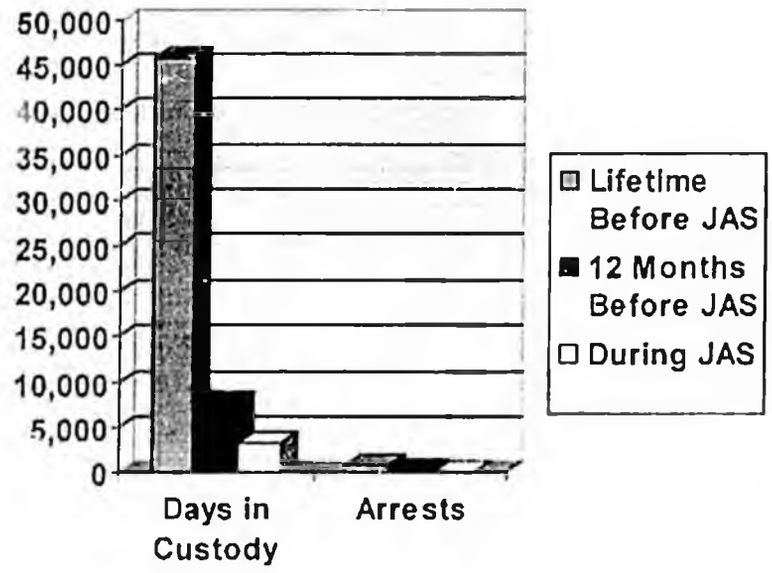
Sources: Jail Alternative Service Program Evaluation July 1, 1998 – June 30, 2003, C&S Management Associates, 2004. Alaska Mental Health Trust Authority Status Report, Jail Alternative Services, which included data from program inception July 1, 1998 through June 30, 2003, dated April 12, 2004, by Colleen Patrick-Riley, Department of Corrections Mental Health.

Figure 8A: Arrest Data for Individuals Who Participated in Jail Alternative Services (JAS)



(Revised February, 2007)
Source: JAS Program Evaluation, July 1, 1998-June 30, 2003; C&S Management Associates, 2004

Figure 8B: Days in Custody and Arrest Data for Individuals Who Participated in Jail Alternative Services (JAS)



(Revised February, 2007)
Source: JAS Program Evaluation, July 1, 1998-June 30, 2003; C&S Management Associates, 2004

Living with Dignity

Living with dignity can be defined as being valued and appreciated by others for the choices and contributions one makes and being able to take advantage of the opportunities available to all Alaskans. The Comprehensive Plan focuses on three issues related to life with dignity: community participation, housing, and education and training.

To be part of a neighborhood, live in acceptable housing and attend the public school are marks of community membership. Alaskans experiencing mental illness, substance use disorders, developmental disabilities, and age-related dementia need to engage with family, friends, and neighbors and participate in their communities. Social contributions can include volunteer or paid work, subsistence activities, active membership in spiritual and other community organizations, and successful school attendance. People with cognitive or developmental disabilities may need support and assistance to connect with and become contributing members of their communities. Prejudice may limit social acceptance in school, religious organizations and volunteer activities. In some communities, unavailability of transportation services can limit participation in community life.

While many Alaskans struggle to find decent, affordable housing, people with cognitive or developmental disabilities and their families often find it especially difficult to obtain appropriate housing because they are more often poor and because they face discrimination. Poverty makes a person particularly vulnerable to homelessness: an individual may be less than a paycheck away from losing shelter. Many of Alaska's homeless are people with mental, developmental or cognitive disabilities or addictive diseases. Once people are homeless, finding and keeping a treatment schedule becomes even more difficult.

Gaining new skills and experiences in supported environments can prepare adolescents and adults with cognitive or developmental disabilities for jobs and participation in community life. All children are entitled to a public school education where they learn the social, academic and practical skills needed to become adults who are as independent as possible. Children can progress further when developmental delays are identified and addressed early. Schools can also help in identifying students with emotional disturbances and referring them to behavioral health care providers. Schools can educate all children about addictive disorders and healthy lifestyles.

Dignity Goal #1: Make it possible for Trust beneficiaries to be productively engaged in meaningful activities throughout their communities.

The Client Status Review (CSR) tracks the quality of life of consumers of the Alaska behavioral health treatment system. When clients enter the system they are asked a series of questions about their "life domains" such as thoughts of self-harm, feelings of

connectedness, productivity, etc. For comparison, they are asked the same questions at different intervals during treatment, and at discharge. Figures 9A and 9B show the percentage of consumers who reported that their conditions were the same or better than they had been when they entered the system. Included are 1,688 consumers (419 children and 1,269 adults) in state fiscal year 2006.

Figure 9A: Positive Outcomes in Life Domains – Adults (Percentage of Adult Behavioral Health Consumers Improving or Maintaining Quality of Life)

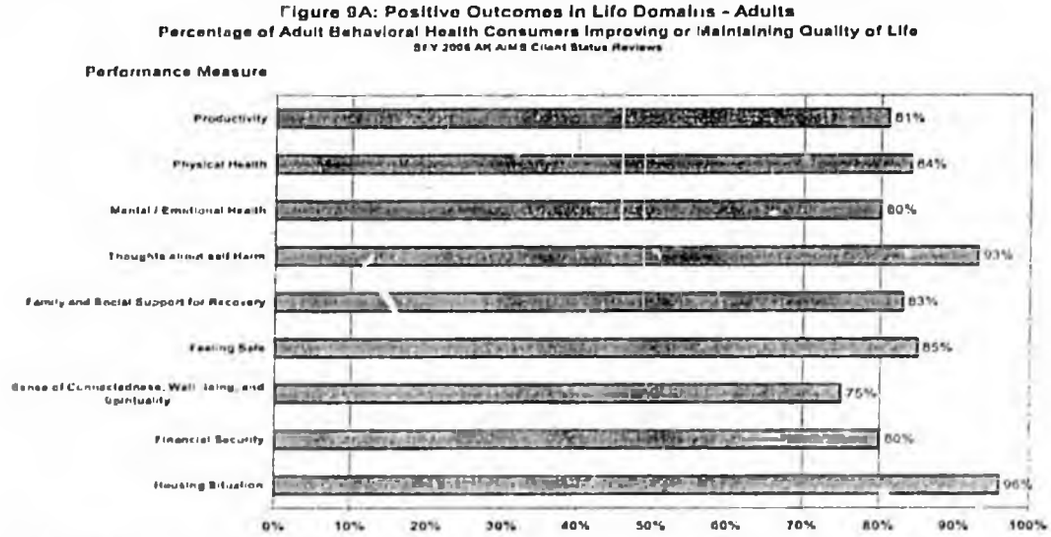
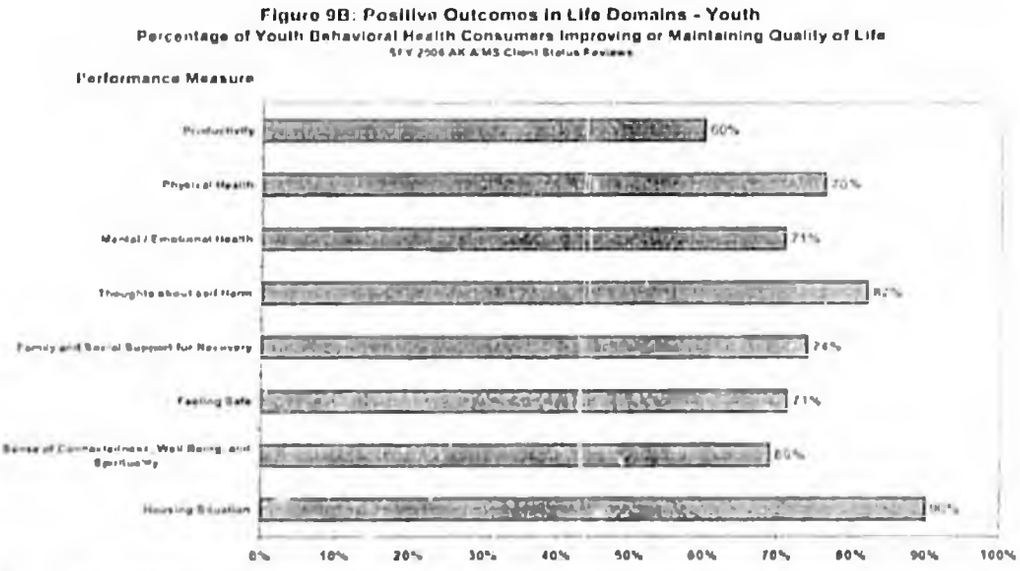


Figure 9B: Positive Outcomes in Life Domains – Youth (Percentage of Youth Behavioral Health Consumers Improving or Maintaining Quality of Life)



Youth connectedness at levels of family, school, and community - Youth Risk Behavior Survey 2003 Report [22]

Connectedness is a key protective factor correlated with a decrease in youth risk behaviors (use of tobacco, alcohol and other drugs, suicide ideation, violence and early sexual activity).[29] The term "connectedness," in this context, refers to the feeling of support and connection youth feel from their school and their community. Youth who help others or who are engaged in community service activities are less likely to be involved in anti-social behaviors, to be suspended from school or to become pregnant.[30] Service activities also provide an opportunity for youth to form close relationships with caring adults.

The 2003 Youth Risk Behavior Survey[22] shows that among Alaska high school students:

- 79.3 percent of boys and 78.1 percent of girls report they don't feel alone in life.
- Most Alaska high school students, 71.0 percent of boys and 74.6 percent of girls, believe they matter to people in their community.
- The majority of boys (60.0 percent) and girls (55.0 percent) report they have teachers who care about them and give encouragement.
- Forty-eight percent of students agree or strongly agree that in their community they feel they matter to people.

Dignity Goal #2: Enable Trust beneficiaries to live in appropriate, accessible and affordable housing in communities of their choice.

On any given night in Alaska, there are an estimated 3,500 homeless Alaskans. Of these, 35 percent suffer from chronic substance abuse problems, 21 percent are severely mentally ill, 19 percent have a dual diagnosis, and 36 percent live with a disability.[31] At least 3000 children were homeless or inadequately housed during the 2005-2006 school year. [32] These children are more likely to experience conditions of anxiety, withdrawal, depression, hunger, asthma, ear infections, stomach problems and speech problems than their peers.

Homelessness results from a complex set of circumstances that require people to choose between food, shelter, and other basic needs. Contributing factors include:

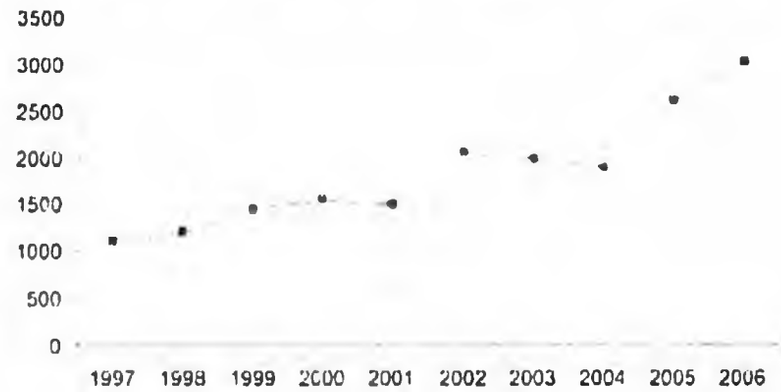
- **Inadequate income.** A 2001 study found 57% of Alaska households could not afford a median-priced home and 46% could not afford the average rent.[33] In Anchorage, a person needs to earn $18.12 per hour to afford a modest two-bedroom apartment at the average fair market rent of $942.[34] (For more information about rent-wage disparities in Alaska, please see Table E-1.)
- **Inadequate supply of affordable housing.** The private housing market alone cannot supply enough affordable housing because of high land prices and other costs. The waiting list in Alaska for publicly financed housing is over 3,000 households.[35]

- **Catastrophic events and destabilizing forces.** A sudden economic downturn caused by illness, injury, divorce or job loss may push people into homelessness. Mental illness and addiction disorders are also destabilizing forces that can cause homelessness.

Insufficient support'e services. In Alaska, homeless prevention services, case management services, after-hours mental health counseling and other housing retention services are not widely available. Once special needs clients have been placed in housing, there is a great need for "house calls" by occupational therapists or other providers to help the client retain the housing.[37]

Figure 10 — Estimated number of homeless Alaskans: Alaska Housing Finance Corporation Statewide Winter Homeless Survey Reports

Estimated Number of Homeless Alaskans: Alaska Housing Finance Corporation Statewide Winter Homeless Survey Reports



Source: Alaska Housing Finance Corporation Homeless Service Providers Survey Reports
Data reflects total homeless numbers reported by agencies, with duplicates removed

Figure 10 shows that the estimated number of homeless Alaskans doubled between 2001 and 2006. The AHFC survey is completed semiannually on a predetermined day by providers of services for homeless people. Although the survey has many limitations, including low survey return rates, it does provide some idea of the number of homeless Alaskans and their characteristics.

Section 8 Public Housing

Over 4,000 Alaska residents currently are using Section 8 public housing vouchers, which are allocated from the U.S. Department of Housing and Urban Development to the Alaska Housing and Finance Corporation's Public Housing Division. In addition, as of July 2, 2007, there were 3,020 households still waiting for Section 8 vouchers. The number of vouchers allocated from HUD to AHFC is currently limited to 4,183, thus the need is greater than the supply.[35]

Homeless Bed Inventory

According to the Alaska Housing and Finance Corporation, the 2007 Homeless Bed Inventory showed 1,265 emergency shelter beds and 690 transitional housing beds for a total of 1,955 temporary beds in Alaska.[36]

Supportive Housing

There are approximately 538 supportive housing units statewide. These units, designed for those who are homeless with special needs, enable people to live as independently as practicable.[37] In supportive housing, residents have their own housing units and lease agreements.

Assisted Living

Throughout Alaska there are 2702 assisted living beds in 506 licensed facilities.[38] Assisted living is a more structured and regulated form of special needs housing. More often than not, the landlord and service provider are the same and housing tenancy is tied to using the services provided. Many of these required services are related to activities of daily living. In Alaska, virtually all of the special needs housing for persons with developmental disabilities are licensed assisted living homes.

Number of individuals discharged to homeless situations from Alaskan institutions: Alaska Psychiatric Institute (API)

When Alaska Psychiatric Institute patients return to their home community, staff works to identify appropriate living arrangements whenever possible. Those who are homeless at discharge are typically referred to shelters in the community. Over the last six years, an average of 88 discharges a year have led to homeless status.[39]

Alaska Department of Corrections

A 2005 Department of Corrections Homeless Offender survey found that 35% of offenders did not know where they would live upon release or planned to live in a shelter or on the street.[40]

Dignity Goal #3: Assist Trust beneficiaries to receive the guidance and support needed to reach their educational goals.

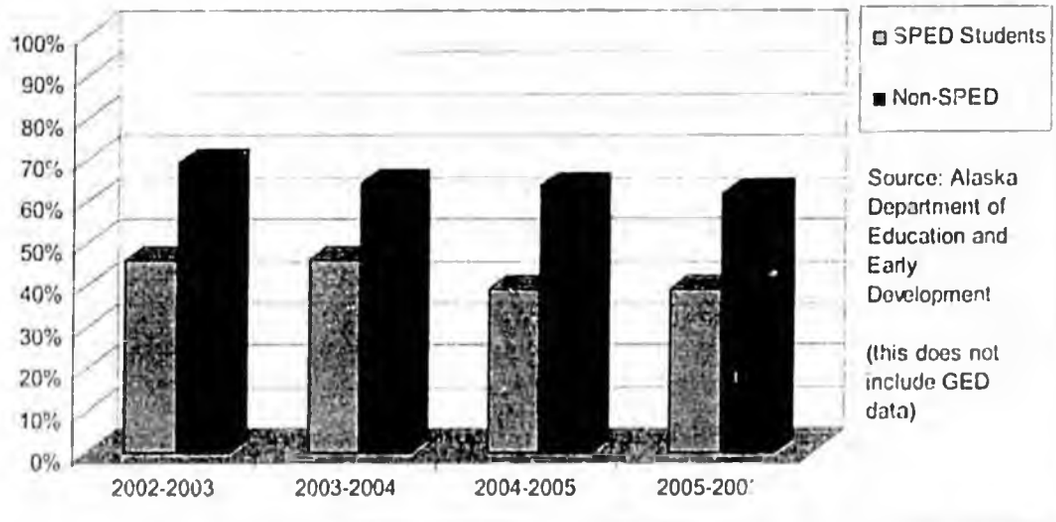
The federal Individuals with Disabilities Education Act (IDEA)[19] is the primary law that entitles children with disabilities to a free and appropriate education. IDEA requires states to provide special education and related services to students who meet eligibility requirements. To be eligible, a student must meet criteria established in the law and the condition must adversely affect his or her educational performance. Children with disabilities must be taught in the least restrictive environment and among non-disabled children to the maximum extent appropriate.

IDEA requires schools to provide necessary accommodations, as identified in each student's required Individual Education Plan, for special education students to participate in the high school exit examination. This accommodation includes development of an alternate assessment for students with significant disabilities. It is critical for children to participate in school and complete a high school course of study as part of their preparation for a life as independent as possible.

Figure 11 — High School Graduation Rates for Students Receiving Special Education Compared with Students Not Receiving Special Education

Figure 11 shows the rate of students who graduated from Alaska's public high schools with a regular diploma. Between 2002 and 2006 there was a slight decline in graduation rates among all students. During that time the graduation rates for Alaskans who received special education services were 18 to 23 percent lower than the rates for those who did not receive special education services.

Figure 11: High School Graduation Rates for Youth Receiving Special Education Compared with Youth not Receiving Special Education



Alaska loses a significant number of students over their four years of high school. Reasons for discontinuing school include pursuing a GED, entering the military, becoming employed, facing family problems, illness, pregnancy, or alcohol/drug dependency, failing, truancy, being expelled due to behavior, transferring to non-district sponsored home schooling, or leaving for unknown reasons without a formal request for transfer of records. Part of the recent decline in overall graduation rates may be tied to better record keeping and reporting in the districts.

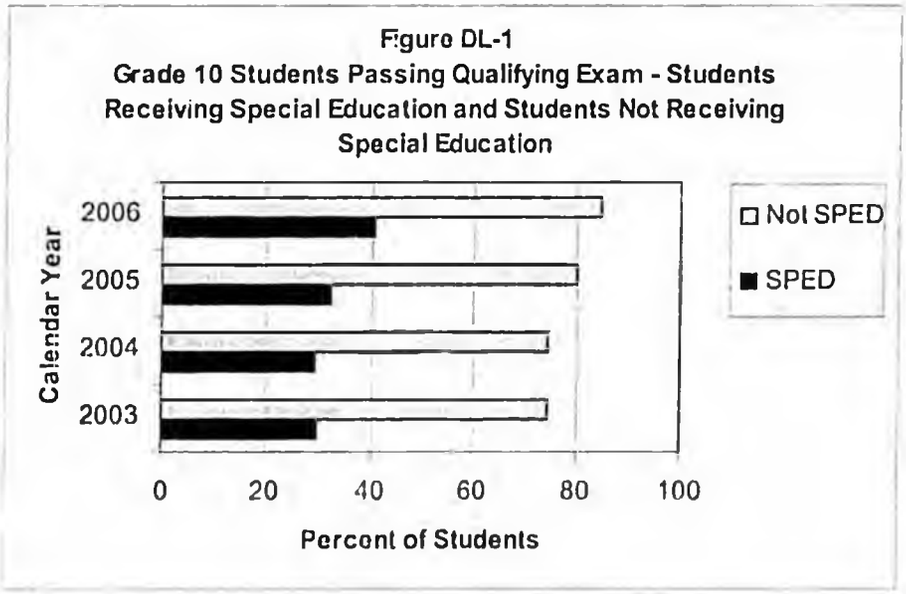
The data used to generate the graduation rate is the same for all students, whether or not they are on an Individual Education Plan. The actual yearly graduation rate is computed by determining the total number of graduates divided by the sum of the continuing 12th

grade students plus the total of yearly "drop-outs" for each of the four preceding years (i.e., a cohort model).

In the 2003-04 school year, the state offered a one-year waiver to all special education students so that if they met all other graduation requirements in their district, they were granted a diploma without having passed the High School Graduate Qualifying Exam (HSGQE- high school exit exam). This caused a one -year spike in the Special Education graduates. The 2004-05 graduate counts returned to the historical norm.

Figure DL-1 - Grade 10 Students Passing Qualifying Exams – Students Receiving Special Education Services and Students Not Receiving Special Education Services

Figure DL-1 shows the percentage of 10th Grade students enrolled in special education who scored above proficiency in reading, writing, and math on the High School Graduate Qualifying Exam, as compared to the students not receiving special education who also scored above proficiency. Overall, more students passed the exams in 2006 than in 2005. The rate of passage for those receiving special education is consistently less than half the rate for those not receiving special education. These percentages are statewide and include only the students who participated in the exams.



Economic Security

"Economic security" means that people are able to provide basic necessities for themselves and their families. Many Trust beneficiaries must rely on public assistance to meet basic needs because they are unable to work or engage in subsistence activities.. Unfortunately, public assistance has not kept pace with the cost of living, and poverty is common among Trust beneficiaries and their families. Alaskans living with mental health problems and developmental or cognitive disabilities who are able to work can be helped in this effort by continued Medicaid and assistance with expensive medications needed for the treatment of their illness.

Economic Security Goal #1: Make it possible for Trust beneficiaries most in need to live with dignity, ensuring they have adequate food, housing, medical care, work opportunities, and consistent access to basic resources.

Figure 12 — SSI/APA Payment Compared to Alaska Poverty Level

The Supplemental Security Income (SSI)/Adult Public Assistance (APA) cash benefit for people with disabilities has eroded over the years in relation to the Alaska poverty level. In Alaska, the SSI/APA programs combine to provide minimal cash assistance of $985 dollars a month to elderly, blind, or disabled individuals. While the SSI payment is adjusted every year for inflation, the APA payment is legally capped and therefore diminishes in value every year due to inflation

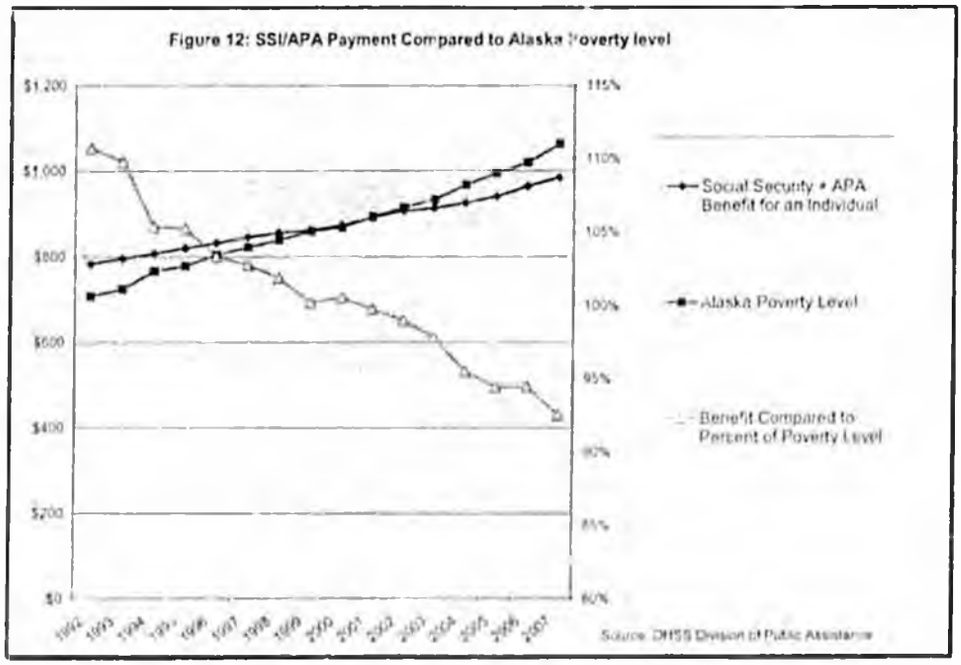


Figure 13 — Alaska Population 18 and Over by Income Level and Disability Status, 2005-2006

Behavioral Risk Factor Surveillance Survey data from 2005 and 2006 show that Alaskans experiencing a disability (i.e., limited in any way in any activities because of physical, mental or emotional problems) have a significantly lower annual income than those not experiencing a disability.

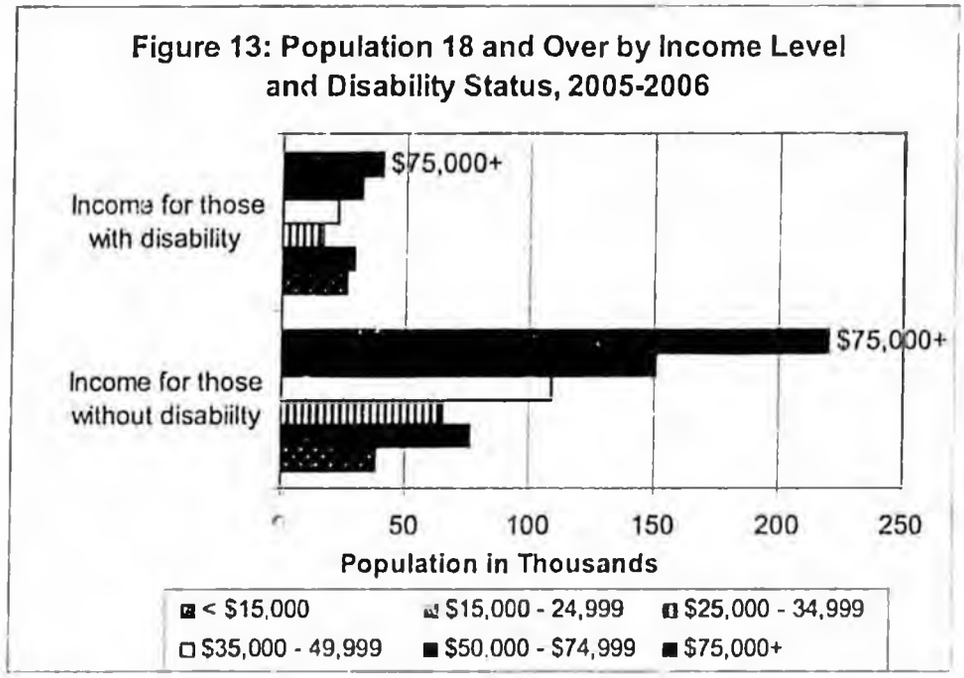
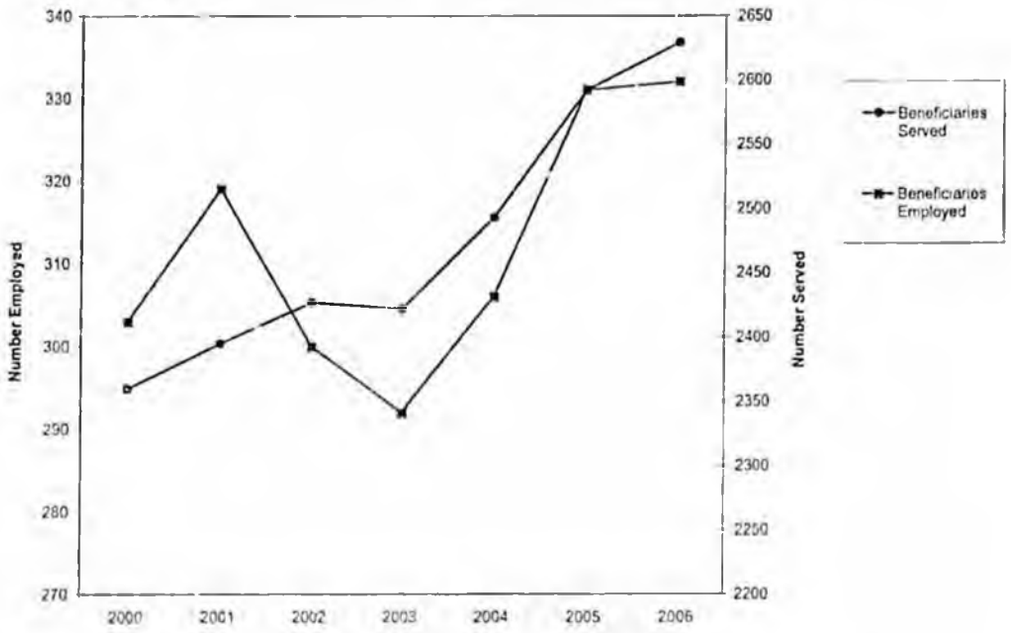


Figure 14 — Number of Trust Beneficiaries Receiving Support through Division of Vocational Rehabilitation versus Number Employed

The Division of Vocational Rehabilitation (DVR) assists individuals with a disability to obtain and maintain employment. With the proper services and supports, such as education, on-the-job training, job search, and placement services, people with disabilities can be employed. Of the total clients served by DVR in 2006, 68 percent were Trust beneficiaries. Trust beneficiaries comprised 61 percent of the total clients receiving training, and 63 percent of the total becoming employed.

Figure 14 shows that over the last six years, the number of Trust beneficiaries served by DVR has steadily grown by over 11 percent and the number who became employed grew approximately 8.5 percent. Although DVR has increased community outreach, cases can take years to reach a successful outcome, thus outcomes lag behind the number served.

Figure 14
Number of Trust Beneficiaries Receiving Support through
Division of Vocational Rehabilitation vs. Number Employed



Source: AK Department of Labor and Workforce Development, Division of Vocational Rehabilitation

Employment initiatives of DVR with a focus on Trust beneficiaries include the Customized Employment Grant (CEG), supported employment services, and micro-enterprise grants from The Trust. The goal of the CEG is to build the capacity in Job Centers in Juneau, Kenai, Anchorage, Wasilla and Fairbanks to better serve people with severe disabilities so that they have a more responsive and individualized employment relationship based on their strengths, needs and interests, while meeting the needs of the employer. The micro-enterprise grants require DVR to match the funds and focus on self-employment ventures. Supported employment is a service delivery system within the vocational rehabilitation program to provide employment opportunities to individuals who require intensive services to gain employment and extended services to maintain employment.

Figure ES-1: MR/DD Waiver Recipients who Receive Supported Employment Services

Figure ES-1 shows that approximately 320 MR/DD waiver recipients have received supported employment services annually for the last five years. "Supported employment" is paid employment for persons with developmental disabilities for whom competitive employment at or above the minimum wage is unlikely and who, because of their disabilities, need intensive ongoing support, including supervision and training, to perform in a work setting. Medicaid covers the costs of supported employment for people with developmental disabilities, allowing participants to contribute to the community and to their own sense of self-esteem through work.

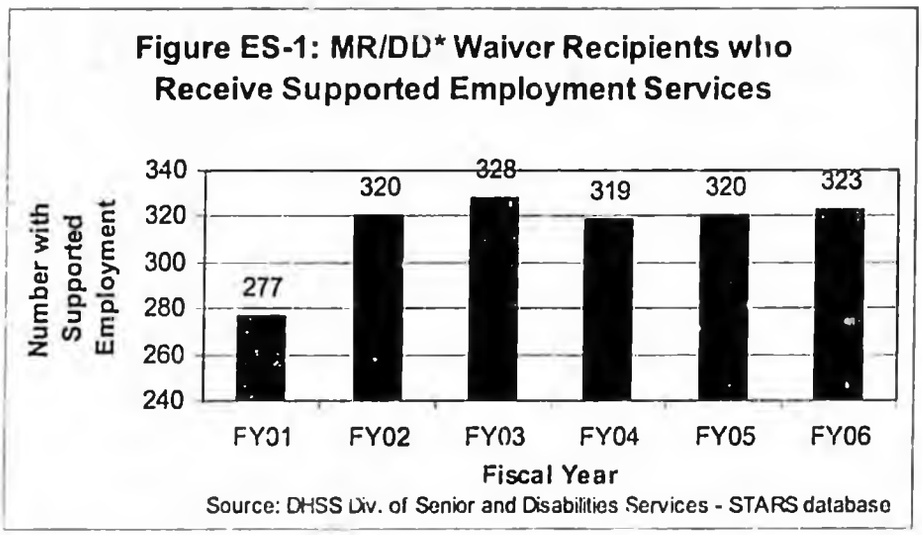
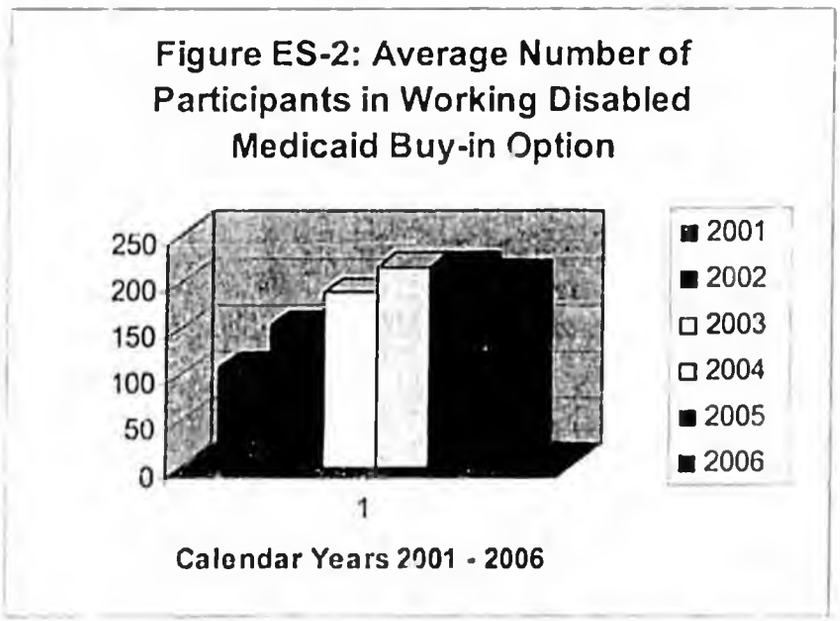


Figure ES-2 - Average Number of Participants in the Medicaid Buy-in Option

The Working Disabled Medicaid Buy-in is a category of Medicaid intended to encourage an individual with a disability to work (if they are able) by giving or extending their access to health coverage. Alaska was the first state to pass legislation that provides for this program and participation has doubled since 2001. To participate in the buy-in program, family income cannot exceed 250 percent of federal poverty guidelines for Alaska, and the individual's monthly unearned income must be less than $1156 ($1390, if married) and countable assets of less than $2000 ($3000, if married).



Source: AK DHSS Div. of Public Assistance Eligibility Information System

Affordability of Housing

Many Alaskan families cannot afford adequate housing. A minimum wage worker in Alaska earns $7.15 per hour. The average Fair Market Rent (FMR) for a two-bedroom apartment in Alaska is $931. For this level of rent and utilities to be considered affordable, a minimum wage earner must work 100 hours per week, 52 weeks per year. Or, a household must include 2.5 minimum wage earner(s) working 40 hours per week year-round. A housing unit is considered affordable if it costs no more than 30 percent of one's income.

The following chart shows how much money a person in each Alaska census area would need to earn in order for them to be spending only the recommended 30 percent of their income on a typical two-bedroom rental. For instance, a person renting a two-bedroom apartment in Mat-Su would need to earn $15.33 per hour working fulltime. But if they were only able to earn minimum wage, they would need to work 86 hours per week.

An Alaskan household must earn $3,103 monthly or $37,235 annually to afford the average unit. This translates into an hourly wage of $17.90, based on a 40-hour work week, 52 weeks per year.
For more information about homelessness, please see the Living with Dignity section

TABLE ES-1
Alaska Rent-Wage Disparities

Community	Affordable Rent*	SSI/APA Affordable Rent	2-BR FMR	Wage Needed to Afford 2-BR FMR	Hrs pr wk @ Min Wage**
			Fair Market Rent	Per Hour	
Anchorage	$577	$290	$942	$18.12	101
Barrow	$588	$290	$1,104	$21.23	119
Bethel	$339	$290	$1,213	$23.33	131
Dillingham	$420	$290	$1,004	$19.31	108
Fairbanks	$526	$290	$859	$16.52	92
Juneau	$652	$290	$1,096	$21.08	118
Kenai	$499	$290	$732	$14.08	79
Ketchikan	$545	$290	$962	$18.50	103
Kodiak	$547	$290	$1,034	$19.88	111
Mat-Su	$528	$290	$797	$15.33	86
Nome	$407	$290	$1,030	$19.81	111
Sitka	$578	$290	$920	$17.69	99
Unalaska	$458	$290	$1,004	$19.31	108
Valdez	$559	$290	$907	$17.44	98

Source: National Low Income Housing Coalition www.nlihc.org "Out of Reach" 2006 report

*Affordable rent means monthly rent affordable to a household earning 30% of Annual Median Income, applying the generally accepted standard of spending not more than 30% of income on housing costs

** Minimum wage of $7.15 hr, effective 1/1/03

FMR-Fair Market Rent as issued by HUD 10/1/2006

III. Current Services and Service Gaps Analysis

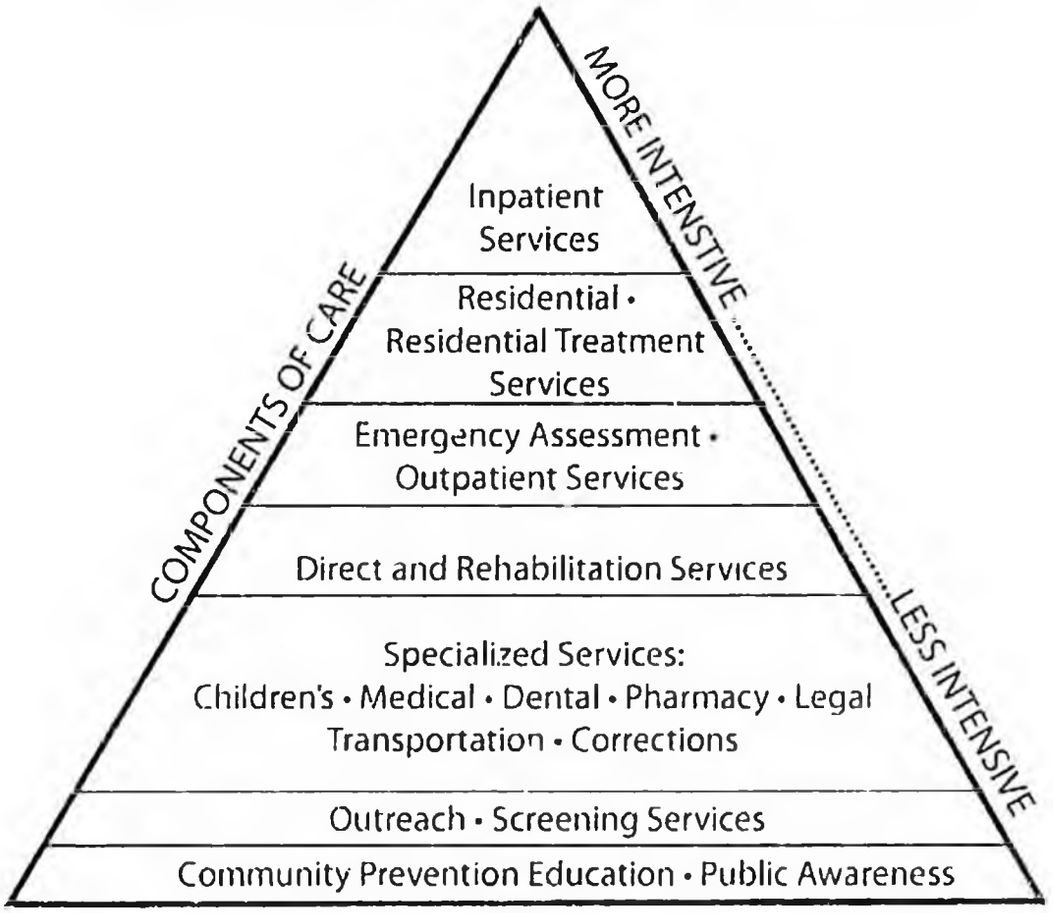
Services for Alaskans experiencing developmental disabilities, alcoholism or other drug addictions, mental or emotional illnesses, and Alzheimer's disease or other dementias were originally shaped and frequently compartmentalized by federal funding availability and federal program requirements. Advocates and program managers have long recognized that service integration is a first step toward higher quality services, increased access to services, and greater cost savings. In addition, many people experience more than one beneficiary disability during the course of their lifetimes. Simplifying and coordinating services for people with multiple cognitive or developmental disabilities is both cost effective and provides better care. Initiatives, discussed in a later section, address gaps in service delivery systems.

Figure 15 — Components of Care for Three or More Beneficiary Groups

The Trust and the Department of Health and Social Services support the components of care illustrated in Figure 15, ranging from prevention at the bottom to acute care at the top for people requiring intensive care. Public education and prevention services, which reach large audiences, are listed at the bottom of the diagram. Services in the middle of the triangle are home and community-based and are used by people requiring a less intensive level of care.

Although economies of scale restrict some services to urban areas, the Plan's vision is that appropriate services would be available when needed across the state. The components of care listed are only those that serve three or more beneficiary groups. These are the same services listed in the Matrix on the following page.

Figure 15
Components of Care for Three or More Beneficiary Groups



Current Services

Table 2 shows the geographic availability of services that are needed by three or more Trust beneficiary groups.

Table 2— Matrix of Current CIMHP Services

Matrix of Current CIMHP Services for Three or More Trust Beneficiary Groups

Service	Level 1: Village	Level 2: Subregional Center or town	Level 3: Regional Center or Small City	Level 4: Urban Center	Level 5: Metropolitan Area
Population	25+ in immediate community.	500+ in immediate community; a sub-regional population of at least 1,500.	2,000+ in immediate community, providing services to a regional population of at least 5,000	25,000 + in immediate community providing services to a larger regional or statewide population	200,000 + in immediate community.
Inpatient services	⊏	⊏	✧	◆	◆
Residential Services	⊏	⊏	•	✧	✧
Emergency/ Assessment / Outpatient Services	•	✧	✧	◆	◆
Direct and Rehabilitation Services	•	✧	✧	✧	✧
Specialized Services					
Children's Services	•	•	✧	✧	✧
Medical services – specialized	⊏	⊏	◆	✧	✧
Dental services – specialized	⊏	⊏	✧	✧	◆
Pharmacy services	•	◆	◆	◆	◆
Legal services	✧	✧	✧	✧	✧
Transportation services – specialized	•	•	✧	✧	✧
Corrections services	⊏	⊏	•	✧	✧
Outreach/Screening	•	•	✧	✧	✧
Community Prevention, Education, Public Awareness	•	•	✧	✧	✧

◆ Available (adequate): the service is widely available and meets most needs

✧ Sometimes available (gaps exist): the service is currently available in many communities of that size but not in all such communities, or is not available to all eligible individuals due to inadequate resources.

• Minimally available (needed): the service is mostly unavailable.

⊏ There is not general agreement that these services are feasible at this level of community.

Service Gaps Analysis

The matrix in Table 2 represents a first effort to analyze those similar services provided by separate service delivery systems to different Trust beneficiary groups. Planning staff (DHSS, The Trust, AMHB, ABADA, GCDSE, ACoA, and the Department of Corrections) developed this matrix by comparing service definitions used by different programs and coming to agreement about common definitional elements and suitable aggregate definitions. Next, based on the common definitions, the group assessed service availability using the Alaska Mental Health Board's Level of Community template. This

assessment was based on data and documents produced by the agencies represented by the planning staff.

Development of the matrix assists in considering collaborative approaches and in determining priorities for service needs. Several observations can be made from the matrix:

- Many commonalities exist among services to beneficiaries, especially in such specialized services as medical, dental and pharmacy services.
- The more specialized the service, the more likely it is to have substantial gaps in delivery. For example, even in Alaska 's metropolitan area (Anchorage), gaps exist in direct and rehabilitation care, the foundation of personal support and recovery: even when a service is available, "gaps" may reflect a lack of capacity to serve all who need that service.
- Access to care and participation in community life may require specialized transportation, a service that is needed across all levels of community.
- The matrix also shows that despite efforts to develop services in regional centers, this strategy has not yet produced a full range of adequate care in those areas.
- Below the regional center level, many gaps exist, both for individualized services and for facility based care.

Some service delivery programs, notably those for people with Alzheimer's disease or similar dementia and for people with developmental disabilities, try to meet each person's particular needs in their own homes. Ideally, this would mean that all services could be made available at each level of community. However, the reality is that resources frequently limit such delivery. Often, providers may not be available in a community, but more commonly, resources do not meet current need. For example, about 1,006 people with developmental disabilities were waiting for services at the end of fiscal year 2006.[40]

The Trust and the Department have targeted development of infrastructure and resources for many of these services.

Continuum of Care Matrices for Trust Beneficiary Groups

Definitions for Levels of Community

LEVELS OF COMMUNITY*					
Characteristics	**Level I: Frontier/Village**	**Level II: Sub-Regional Center or Town**	**Level III: Regional Center or Small City**	**Level IV: Urban Center**	**Level V: Metropolitan Area**
Government	Community or city council, Native Council, incorporated city or unincorporated community.	Incorporated city, may have health powers and may provide health and social services.	Incorporated city or unified municipality, may have health powers and may provide health and social services.	Incorporated, home rule city or unified municipality; may have health powers and may provide health and social services.	Incorporated, home rule city, or unified municipality; may have health powers and may provide health and social services.
Population	25+ in immediate community.	500+ in immediate community; a sub-regional population of at least 1,500.	2,000+ in immediate community, providing services to a regional population of at least 5,000	25,000+ in immediate community providing services to a larger regional or statewide population	200,000+ in immediate community.
Economy	Subsistence, government services (e.g. school)	A developing private sector, some government services; provides some service to surrounding areas.	Regional trade and service center, mixed economy with multiple private and government employers.	Major trade and service center, broad based multi-sector economy.	Principal trade and service center; broad based, multi-sector economy.

Health & Social Services	Community Health Aide, paraprofessional and itinerant services.	Health and social services may be provided by both the private and public sector, community clinic and mid-level provider or MD.	Health care and social service agencies, including both private and government programs; community hospital and physicians.	Multiple providers of health care and other services including both private and government programs; health care specialists; hospitals with full continuum of care.	Level IV plus highly specialized medical and rehabilitation services; specialized hospitals and consulting services.
Access	Usually, more than 60 minutes by year-round ground transportation from a Level II or III community; limited air and/or marine highway access to Level II or III community.	Usually less than 60 minutes by year-round ground transportation from a Level III community; marine highway or daily air access to closest Level III community; airline service to Level I communities in the area.	Daily air service to closest Level IV or V community; airline service to Level I and II communities in the region; road or marine highway access all year.	Daily airline service to Level II, III, IV, and V communities; road or marine highway access all year.	Daily airline service to Level II-IV communities; road or marine highway access all year.
Communities	Too numerous to list, includes Anvik, Eagle, Houston, Ruby, Hydaburg, Wales, Skagway, etc…	Aniak, Craig, Delta Junction, Tok, Emmonak, Fort Yukon, Galena, Haines, Hoonah, Hooper Bay, King Cove, King Salmon/Naknek, Nenana, McGrath, Metlakatla, Mt Village,St. Mary's, Sand Point, Togiak, Unalaska, Unalakleet, Glennallen/ Copper Center	Barrow, Bethel, Dillingham, Homer, Kenai/Soldotna, Ketchikan, Kodiak, Kotzebue, Nome, Palmer/Wasilla, Sitka, Cordova, Petersburg, Wrangell, Valdez, Seward	Fairbanks, Juneau	Anchorage

**Levels of Community Care is a document created by the Alaska Mental Health Board (rev.8/93).*

Continuum of Care Matrix for Alaskans with Behavioral Health Disorders (Mental Illness, Alcoholism, Drug Addictions)

LEVELS OF COMMUNITY *					
Characteristics	**Level I: Frontier/Village**	**Level II: Sub-Regional Center or Town**	**Level III: Regional Center or Small City**	**Level IV: Urban Center**	**Level V: Metropolitan Area**
I. Community Prevention / Education	**I. Community Prevention/Education**	**I. Community Prevention/Education**	**I. Community Prevention/Education**	**I. Community Prevention/Education**	**I. Community Prevention/Education**
	a. Advocacy/self-help	a. Advocacy/self-help	a. Advocacy/self-help	a. Advocacy/self-help	a. Advocacy/self-help
	b. Prevention and intervention	b. Prevention and intervention	b. Prevention and intervention	b. Prevention and intervention	b. Prevention and intervention
	c. Community education	c. Community education	c. Community education	c. Community education	c. Community education
	d. Peer, Consumer, and Client Support	d. Peer, Consumer, and Client Support	d. Peer, Consumer, and Client Support	d. Peer, Consumer, and Client Support	d. Peer, Consumer, and Client Support
	Services	Services	Services	Services	Services
	General Availability?	**General Availability?**	**General Availability?**	**General Availability?**	**General Availability?**
	None	Very limited	Limited capacity	Some capacity	Greatest capacity

II. Behavioral Health Services (a-g)					
a. Outreach	a. Outreach **General Availability?** None	a. Outreach **General Availability?** Very Limited	a. Outreach **General Availability?** Limited capacity	a. Outreach **General Availability?** Some capacity	a. Outreach **General Availability?** Greatest capacity
b. Emergency Services	b. Emergency Services i. 24 hour telephone screening, assessment, triage ii. Crisis Intervention & Stabilization **General Availability?** Very limited	b. Emergency Services i. 24 hour telephone screening, assessment, triage ii. Crisis Intervention & Stabilization **General Availability?** Good capacity	b. Emergency Services i. 24 hour telephone screening, assessment, triage ii. Crisis Intervention & Stabilization **General Availability?** Good capacity	b. Emergency Services i. 24 hour telephone screening, assessment, triage ii. Crisis Intervention & Stabilization **General Availability?** Very good capacity	b. Emergency Services i. 24 hour telephone screening, assessment, triage ii. Crisis Intervention & Stabilization **General Availability?** Very good capacity
c. Assessment	c. Assessment i. screening ii evaluation/referral	c. Assessment i. screening ii evaluation/referral	c. Assessment i. screening ii evaluation/referral	c. Assessment i. screening ii evaluation/referral	c. Assessment i. screening ii evaluation/referral

	General Availability? Very limited	**General Availability?** Good capability	**General Availability?** Good capability	**General Availability?** Excellent capability	**General Availability?** Excellent capability
d. Outpatient (Clinic-Based) Services	d. Outpatient Services i. Screening ii. Face-to-Face assessment & triage (SA;MH; TBI) iii Treatment Planning iv. Counseling (1:1; Group) **General Availability?** None	d. Outpatient Services i. Screening ii. Face-to-Face assessment & triage (SA;MH; TBI) iii Treatment Planning iv. Counseling (1:1; Group) **General Availability?** Limited capacity	d. Outpatient Services i. Screening ii. Face-to-Face assessment & triage (SA;MH; TBI) iii Treatment Planning iv. Counseling (1:1; Group) **General Availability?** Good capacity	d. Outpatient Services i. Screening ii. Face-to-Face assessment & triage (SA;MH; TBI) iii Treatment Planning iv. Counseling (1:1; Group) **General Availability?** Excellent capability	d. Outpatient Services i. Screening ii. Face-to-Face assessment & triage (SA;MH; TBI) iii Treatment Planning iv. Counseling (1:1; Group) **General Availability?** Excellent capability
e. Rehabilitation & Recovery Services	e. Rehabilitation & Recovery Services i. Case Management ii. Skill Development iii. Day Treatment iv. School/home-based	e. Rehabilitation & Recovery Services i. Case Management ii. Skill Development iii. Day Treatment iv. School/home-based	e. Rehabilitation & Recovery Services i. Case Management ii. Skill Development iii. Day Treatment iv. School/home-based	e. Rehabilitation & Recovery Services i. Case Management ii. Skill Development iii. Day Treatment iv. School/home-based	e. Rehabilitation & Recovery Services i. Case Management ii. Skill Development iii. Day Treatment iv. School/home-based

	services v. Supported Living vi. Individualized services vii. Intensive outpatient services **General Availability?** None	services v. Supported Living vi. Individualized services vii. Intensive outpatien. services **General Availability?** Very limited	services v. Supported Living vi. Individualized services vii. Intensive outpatient services **General Availability?** Good capacity	services v. Supported Living vi. Individualized services vii. Intensive outpatient services **General Availability?** Excellent capacity	services v. Supported Living vi. Individualized services vii. Intensive outpatient services **General Availability?** Excellent capacity
f. Medical Services	f. Medical Services i. Psychiatric Assessment ii. Pharmacological Management iii. Medical Co-morbidity **General Availability?** None	f. Medical Services i. Psychiatric Assessment ii. Pharmacological Management iii. Medical Co-morbidity **General Availability?** Limited	f. Medical Services i. Psychiatric Assessment ii. Pharmacological Management iii. Medical Co-morbidity **General Availability?** Good capacity	f. Medical Services i. Psychiatric Assessment ii. Pharmacological Management iii. Medical Co-morbidity **General Availability?** Good capacity	f. Medical Services i. Psychiatric Assessment ii. Pharmacological Management iii. Medical Co-morbidity **General Availability?** Good capacity

Detoxification Services	g. Detoxification i. social detox ii. outpatient detox iii. medical detox **General Availability?** None	g. Detoxification i. social detox ii. outpatient detox iii. medical detox **General Availability?** Very limited	g. Detoxification i. social detox ii. outpatient detox iii. medical detox **General Availability?** Very Limited	g. Detoxification i. social detox ii. outpatient detox iii. medical detox **General Availability?** Limited	g. Detoxification i. social detox ii. outpatient detox iii. medical detox **General Availability?** Limited
III. Residential Services					
a. Children Services	a. Day Treatment b. Foster Homes c. Therapeutic Group Homes d. Emergency Stabilization & Assessment e. Residential Treatment f. Secure Locked Residential Care	a. Day Treatment b. Foster Homes c. Therapeutic Group Homes d. Emergency Stabilization & Assessment e. Residential Treatment f. Secure Locked Residential Care	a. Day Treatment b. Foster Homes c. Therapeutic Group Homes d. Emergency Stabilization & Assessment e. Residential Treatment f. Secure Locked Residential Care	a. Day Treatment b. Foster Homes c. Therapeutic Group Homes d. Emergency Stabilization & Assessment e. Residential Treatment f. Secure Locked Residential Care	a. Day Treatment b. Foster Homes c. Therapeutic Group Homes d. Emergency Stabilization & Assessment e. Residential Treatment f. Secure Locked Residential Care

	General Availability? None	**General Availability?** Very limited	**General Availability?** Limited Capacity	**General Availability?** Good capacity	**General Availability?** Good capacity
b. Adult Services	a. Crisis Respite b. Residential Treatment **General Availability?** None	a. Crisis Respite b. Residential Treatment **General Availability?** None	a. Crisis Respite b. Residential Treatment **General Availability?**	a. Crisis Respite b. Residential Treatment **General Availability?**	a. Crisis Respite b. Residential Treatment **General Availability?**
IV. Inpatient Services (Acute)	a. Acute Psychiatric Care b. DET / DES **General Availability?** None	a. Acute Psychiatric Care b. DET / DES **General Availability?** None	a. Acute Psychiatric Care b. DET / DES **General Availability?** Very limited	a. Acute Psychiatric Care b. DET / DES **General Availability?** Limited	a. Acute Psychiatric Care b. DET / DES **General Availability?** Good

Definitions for Continuum of Care Matrix for Alaskans with behavioral health disorders (mental illness, alcoholism, drug addictions)

Community Prevention/Education: Community interventions and education that ward off the initial onset or risk of a substance use or mental disorder or emotional or behavioral problem, including prevention of co-occurring substance use and mental health disorder. Community prevention/education examples include peer/consumer and client support services; community education; advocacy/self-help; and prevention.

Outreach: Facilitate entry into treatment or meeting the individual within their community, job, home or school setting to engage in treatment or support services for either a substance use or mental disorder or for those individuals experiencing co-occurring mental health and substance use disorders. **(Agency Defined).**

Emergency Services: are provided in a crisis situation during an acute episode of a substance use, mental, emotional or behavioral disorder. Emergency services are intended to reduce the symptoms of the disorder, prevent harm to the recipient or others; prevent further relapse or deterioration of the recipient's condition; or to stabilize the recipient. Inpatient Medical Detox is also included in this section. This level of detoxification provides the highest level of monitoring. Placement criteria are defined by the presence of high risk factors for complicated withdrawal: high risk biomedical complications, psychiatric or behavioral complications.

Detoxification Services: Detoxification is a process involving multiple procedures for alleviating the short-term symptoms of withdrawal from drug dependence. The immediate goals of detoxification are 1) to provide a safe withdrawal from the drug(s) of dependence and enable the client to become drug free; 2) to provide withdrawal that is humane and protects the client's dignity; and 3) prepares the client for ongoing treatment of alcohol or drug dependence.

Social Detox: This is a model of detoxification that requires no medication, and allows the client to withdraw from abused chemicals in a safe environment.

Outpatient Detox : The client is at minimal risk from severe withdrawal, which requires moderate levels of medication and monitoring.

Medical Detox: This level of detoxification provides the highest level of monitoring. Placement criteria are defined by the presence of high risk factors for complicated withdrawal: high risk biomedical complications, psychiatric or behavioral complications.

Assessment: A face-to-face, computer assisted, or telephone interview with the person served to collect information related to his or her history and needs, preferences, strengths, and abilities in order to determine the diagnosis, appropriate services, and /or referral for services to address substance use and or mental disorders. The type of assessment is determined by the level of entry into services and the qualified staff delivering the service: Intake Assessment, Drug/Alcohol Assessment, Psychiatric Assessment, Psychological Assessment, Neuro-Psychological Testing and Evaluation.

Outpatient (Clinic-Based) Services: Refers to a range of facility based behavioral health services that can include assessment, individual, family, and group therapy. These services are designed to treat substance use disorders, mental illness, behavioral maladaption, or other problems: to remove, modify, or retard existing symptoms, attenuate or reverse disturbed patterns of behavior and promote positive recovery, rehabilitation, and personality growth and development.
Note: Screening differs from assessment in the following ways:

Screening is a process for evaluating the possible presence of a particular problem; and,

Assessment is a process for defining the nature of that problem and developing specific treatment recommendations for addressing the problem.

Rehabilitation and Recovery Services: Refers to a range of services that are available to clients who meet criteria based on levels of functioning in multiple spheres. Services can include a functional assessment, case management, individual/family/group skill development, and recipient support services. A functional assessment assists the client in identifying areas of need in developing a treatment plan. Case management services assist the recipient in accessing and coordinating needed services, such as medical, substance use, psychiatric, and behavioral health care. Skill development services help the recipient develop or improve specific self-care skills, self-direction, communication and social interaction skills necessary for successful community adjustment and interaction with persons in the recipient's home, school, work, or community environment. Recovery is a treatment philosophy that provides the framework of service delivery. A recovery model offers hope that the restoration of a meaningful life is possible and achievable.

Medical Services: Refers to a range of behavioral health services that are delivered by trained medical staff, and can include psychiatric assessment and pharmacological management, and medical co-morbidity.

Residential Services: Is a licensed 24 hour facility (not licensed as a hospital) which offers behavioral health services which include treatment for substance use disorders; settings range from structured facilities, resembling psychiatric hospitals or drug/alcohol treatment facilities, to those that function as group homes or halfway houses; therapeutic foster care and foster care, family teaching homes, crisis beds, therapeutic group homes, staff-secure crisis/respite group homes, residential case managements specialized drug/alcohol, evaluation/treatment and specialized vocational rehabilitation.

Inpatient Services: Inpatient hospitalization is the most restrictive type of care in the continuum of behavioral health services; it focuses on ameliorating the risk of danger to self or others in those circumstances in which dangerous behavior is associated with substance use or mental disorder. Services include facility-based crisis respite, community hospitals, Designated Evaluation and Treatment (DET) beds, and the Alaska Psychiatric Institute (API).

Continuum of Care Matrix for Alaskans with Developmental Disabilities

	LEVELS OF COMMUNITY*				
Characteristics	**Level I: Frontier/Village**	**Level II: Sub-Regional Center or Town**	**Level III: Regional Center or Small City**	**Level IV: Urban Center**	**Level V: Metropolitan Area**
I. Information and Referral	Telephonic assistance in completing eligibility applications information about and referral to services described below	Telephonic assistance in completing eligibility applications information about and referral to services described below	assistance in completing eligibility applications information about and referral to services described below	assistance in completing eligibility applications information about and referral to services described below	assistance in completing eligibility applications information about and referral to services described below
II. Direct Services	Case Management/Care Coordination Respite Specialized Medical Equipment Environmental Modifications	Case Management/Care Coordination Respite Specialized Medical Equipment Environmental Modifications	Case Management/Care Coordination Respite Specialized Medical Equipment Environmental Modifications	Case Management/Care Coordination Respite Specialized Medical Equipment Environmental Modifications	Case Management/Care Coordination Respite Specialized Medical Equipment Environmental Modifications

	Day Habilitation Supported Employment / Subsistence Activities Vocational Rehabilitation Transportation Educational services Infant Learning Preschool K-12 Chore Services Intensive Active Treatment Crisis Response Legal Services	Day Habilitation Supported Employment / Subsistence Activities Vocational Rehabilitation Transportation Educational services Infant Learning Preschool K-12 Chore Services Intensive Active Treatment Crisis Response Legal Services	Day Habilitation Supported Employment / Subsistence Activities Vocational Rehabilitation Transportation Coordinated transportation system Educational services Infant Learning Preschool K-12 Chore Services Intensive Active Treatment Crisis Response	Day Habilitation Supported Employment Vocational Rehabilitation Transportation Coordinated transportation system Educational services Infant Learning Preschool K-12 Chore Services Intensive Active Treatment Crisis Response	Day Habilitation Supported Employment Vocational Rehabilitation Transportation Coordinated transportation system Educational services Infant Learning Preschool K-12 Chore Services Intensive Active Treatment Crisis Response

			Medical Dental Pharmaceutical Recreation Legal Services	Medical Dental Pharmaceutical Recreation Legal Services	Medical Dental Pharmaceutical Recreation Legal Services
III. **Residential Services**	In-home Support Shared Care Family Habilitation Supported Living	In-home Support Shared Care Family Habilitation Supported Living	In-home Support Shared Care Family Habilitation Supported Living Group Home	In-home Support Shared Care Family Habilitation Supported Living Group Home	In-home Support Shared Care Family Habilitation Supported Living Group Home

Definitions for Continuum of Care Matrix for Alaskans with Developmental Disabilities

I. Information and Referral is a service whereby individuals and families can learn about the generic and specialized types of services and supports available in Alaska. Assistance in acquiring and completing eligibility paperwork can be provided, and referrals can be made to agencies offering the types of services an individual or family is seeking. This service is provided by a variety of agencies, including Infant Learning and Early Intervention Programs, school districts, Head Start, Public Health Centers, the Department of Health & Social Services, and various non-profit agencies that provide services to individuals and families.

II. Direct Services described below are available to eligible individuals depending on availability of funding.

Case Management/Care Coordination assists persons in gaining access to needed medical, social, educational and other services regardless of the funding source for the services to which access is gained. Case management links persons with complex personal circumstances to appropriate services and insures coordination of those services. This service may include referral services, routine monitoring and support, and/or review and revision of the habilitation plan.

Respite provides relief to caregivers from the everyday stress of caring for an individual who experiences a disability. Respite care can be provided in a variety of settings. Providers are trained in first aid, CPR, behavior and physical management, and information specific to the recipient's needs. Respite care cannot be used for regular childcare or adult day care except for short-term emergency situations.

Specialized Medical Equipment and Supplies are devices, controls or appliances that enable an individual to increase their ability to perform activities of daily living, or to perceive, control or communicate with the environment in which the individual lives. They are also supplies and equipment necessary for the proper functioning of the above medical equipment.

Environmental Modifications are physical adaptations to an individual's home, which are necessary to ensure the health, welfare and safety of the recipient.

Day Habilitation services assist with acquisition, retention or improvement in self-help, socialization and adaptive skills, and may include pre-vocational training or subsistence activities. These services take place in a nonresidential setting, separate from the home in which the individual lives.

Supported Employment services are provided at a work site in which individuals without disabilities are employed. They include the adaptations, supervision and training needed by individual unlikely to obtain competitive employment at or above the minimum wage. Supported employment is for individuals who need intensive, ongoing support, supervision and training to perform in a work setting. Supported employment may include subsistence activities.

Vocational Rehabilitation services include job counseling, referral, on-the-job training, tests and tools to evaluate an individual's talents, short-term job try-out, job search and placement services, interpreter, reading and tutoring services. In some cases additional services may be covered.

Transportation services enable an individual and necessary escort to gain access to home and community-based waiver services or other community services and resources. Transportation may be provided as part of a coordinated transportation system, with public buses, accessible, door-to-door vans and/or taxi service. In smaller communities this service may be provided through social service agencies.

Educational Services are provided to eligible children birth to 3 through the Infant Learning Program, from 3-5 through the school districts and/or Head Start and from 5-22 through the school districts.

Infant Learning Program services include developmental screening, evaluation, and information about the child's strengths and needs, home visits to help the family or caregivers guide their children in learning new skills, physical, occupation or speech therapy, specialized equipment and resources, and assistance in getting other specialized services and care.

Preschool Special Education services are provided to children ages three through five in order to meet their individual needs identified either through the Infant Learning Program or designed by an interdisciplinary team working through an Alaskan school district. These services are developmentally appropriate and include needed physical, occupational and/or speech therapy, and needed adaptive equipment. Services are designed to prepare children for an inclusive kindergarten placement.

Special Education and Related Services encompass the provision of a free and appropriate education to children aged 3-21 who experience a disability and require specialized instruction in the least restrictive environment. Certified special educators and aides provide a range of services including adaptive physical education, individualized help with all school subjects and classes. Public schools are charged with transitioning students to adult life beginning at age 16.The overall goal of special education is to prepare students for independent living and employment.

Chore Services include regular cleaning and heavy household chores within an individual's residence, snow shoveling to provide safe access and egress, and other services necessary to maintain a clean, sanitary and safe environment in the individual's residence.

Intensive Active Treatment are time-limited specific treatments or therapies to address a family problem or a personal, social, behavioral, mental, or substance abuse disorder in order to maintain or improve effective functioning of an individual. These are designed and provided by a professional or paraprofessional working under a professional.

Crisis Response is offered as short-term assistance to people with developmental disabilities and their families. The purpose is to stabilize circumstances in order to keep the family unit intact, prevent an out-of-home placement, or to maximize an individual's ability to function independently in a difficult situation by providing immediate but limited relief. Examples include ground and/or air transportation and lodging, emergency car repairs needed to maintain employment, and emergency utility expenses if there is an immediate health and safety issue.

Medical services include screening, assessment, diagnosis, and treatment. Specialist and sub-specialist care is available in a limited number of larger communities.

Dental services include preventive and restorative care.

Pharmaceutical services provide access to prescribed medications, nutritional supplements, and durable medical supplies and equipment.

Recreational services are frequently offered by parks and recreation programs. Therapeutic and inclusive recreation and the loan of adaptive recreational equipment are also available.

Legal advocacy services for people with disabilities are available. The state's protection and advocacy program provides training in self-advocacy, disability rights, and special education, assists individuals and family members in advocating for their rights, provides legal representation when problems cannot be resolved by other means, and investigates complaints of abuse, neglect and denial of rights. Private attorneys may also provide representation for a fee.

III. Residential Services

In-home Support services are designed to help individuals overcome or cope with functional limitations.

Shared Care is an arrangement whereby an individual spends more than 50% of the time in the home of an unpaid primary caregiver, and the remainder of the time in an assisted living home.

Family Habilitation services are provided to individuals who live more than 50% of the time in an assisted living home or foster home, receiving care from a paid caregiver who is not a member of the individual's family. This residential arrangement does not require the natural family to give up custody or parental rights. Families and the individual may help choose the Family Habilitation home.

Group Homes are provided to individuals 18 years of age or older who live in an assisted living home. Habilitation plans frequently include goals designed to develop relationships and skills that lead toward increased independence.

Supported Living services are provided to individuals 18 years of age or older in the recipient's private residence by a caregiver who does not reside in that residence. Habilitation plans identify the various levels of training and supervision needed by adults moving into or living in settings that maximize their independence.

Continuum of Care Matrix for Older Alaskans and Alaskans with Alzheimer's Disease and Related Dementias

Characteristics	Level I: Frontier/Village	Level II: Sub-Regional Center or Town	Level III: Regional Center or Small City	Level IV: Urban Center	Level V: Metropolitan Area
I. Services for Individuals with Alzheimer's Disease and Related Dementias					
a. Outreach & Education	Information and referral available statewide through SeniorCare toll-free number. Literature, audio/video resources available through Alzheimer's Resource or Geriatric Ed Centers	Information and referral available statewide through SeniorCare toll-free number. Literature, audio/video resources, some trainings available through Alzheimer's Resource or Geriatric Ed Centers	Information and referral available statewide through SeniorCare toll-free number. Aging and Disability Resource Center in Kenai. Literature, audio/video resources, some trainings available through Alzheimer's Resource or Geriatric Ed Centers	Information and referral available statewide through SeniorCare toll-free number. Aging and Disability Resource Center in Juneau . Literature, audio/video resources, trainings available through Alzheimer's Resource or Geriatric Ed Centers	Information and referral available statewide through SeniorCare toll-free number. Literature, audio/video resources, trainings available through Alzheimer's Resource or Geriatric Ed Centers. Statewide conferences.
b. Assessment	Assessment – targeted, personal service.	Assessment – targeted, personal service.	Assessment – targeted, personal service.	Assessment – targeted, personal service.	Assessment – targeted, personal service.

c. Medical	Community Health Aides	Health Clinics, Physician's Assistants, Public Health Nurses	Health Clinics, Physician's Assistants, Public Health Nurses, Nurse Practitioners, physicians, some small communities have hospitals	Health Clinics, Physician's Assistants, Public Health Nurses, Nurse Practitioners, physicians, hospitals	Health Clinics, Physician's Assistants, Public Health Nurses, Nurse Practitioners, physicians, hospitals
d. Pharmaceutical	Prescription medications available primarily through village-based IHS clinics or dispensaries.	Prescription medications available primarily through IHS clinics and some private pharmacies, physicians and nurse practitioners.	Prescription medications available through IHS clinics, hospitals, private pharmacies, physicians and nurse practitioners.	Prescription medications available through IHS clinics, hospitals, private pharmacies, physicians and nurse practitioners.	Prescription medications available through IHS clinics, hospitals, private pharmacies, physicians and nurse practitioners.
e. Home and Community Based Services					
ii. Personal care attendant	Personal care attendant – very limited, not available in many villages due to workforce shortage	Personal care attendant – targeted, personal, very limited, not available in many towns due to workforce shortage	Personal care attendant – targeted personal, dependent on available workforce	Personal care attendant – targeted personal, dependent on available workforce	Personal care attendant – targeted personal, dependent on available workforce
iii. Chore services	Chore services – very limited, not available in most villages due to workforce shortage	Chore services – limited, dependent on workforce availability	Chore services – dependent on workforce availability	Chore services – dependent on workforce availability	Chore services – dependent on workforce availability

iv. Respite	Respite – very limited, not available in most villages	Respite – limited, not available in all towns	Respite – dependent on workforce availability	Respite – dependent on workforce availability	Respite – dependent on workforce availability
v. Adult da, programs for individuals with ADRD. 15 programs across state, two which coordinate with community mental health centers for assessment, referral and medication management.	not available	not available	Adult day programs – limited availability	Adult day programs	Adult day programs
vi. Meals – congregate and home-delivered	Congregate meals very limited, not available in most villages/home delivered meals not available	Congregate meals limited, not available in all towns/ home delivered meals not available	Meals – congregate and home-delivered, one or both available in some communities	Meals – congregate and home-delivered available	Meals – congregate and home-delivered available
viii. Environmental modifications	Environmental modifications – rarely available due to lack of local contractors	Environmental modifications – dependent on availability of local contractors	Environmental modifications – dependent on availability of local contractors	Environmental modifications	Environmental modifications
ix. Specialized medical equipment	Specialized medical equipment – limited availability	Specialized medical equipment – limited availability	Specialized medical equipment	Specialized medical equipment	Specialized medical equipment
f. Family Caregiver Support	Family caregiver support – very limited, not available in most villages	Family caregiver support – limited, not available in all	Family caregiver support – dependent on workforce	Family caregiver support – dependent on workforce	Family caregiver support – dependent on workforce

		towns.	availability	availability	availability
g. Legal Service (AoA funded through Alaska Legal Services	Phone and internet assistance available	Phone and internet assistance available	Legal Service – in person and phone and internet assistance available	Legal Service – in person and phone and internet assistance available	Legal Service – in person and phone and internet assistance available
h. Residential Care					
i. Assisted Living Homes	Not available	Not available	Assisted Living Homes – limited availability	Assisted Living Homes	Assisted Living Homes
ii. Pioneers Homes	Not available	Not available	Pioneers Homes – Ketchikan , Palmer, Sitka	Pioneers Homes – Fairbanks and Juneau	Pioneers Home - Anchorage
iii. Nursing Homes	Not available	Not available	Nursing Homes – limited availability	Nursing Homes	Nursing Homes
II. Specialized Behavioral Health Services for Seniors					
a. Mental Health	Not available	Mental Health for Seniors – limited assessment and referral	Mental Health for Seniors – limited assessment and referral	Mental Health for Seniors – limited assessment and referral	Not available
b. Chemical Dependency	Not available	Chemical Dependency – limited assessment and referral	Chemical Dependency – limited assessment and referral	Chemical Dependency – limited assessment and referral	Chemical Dependency Treatment – Inpatient elders program

Definitions for Continuum of Care Matrix for Alaskans with Alzheimer's Disease and Related Dementias

Outreach, Education, Information and Referral:

This category of service provides for outreach, education, information and referral of issues related to ADRD for individuals and their caregivers. This is accomplished through the Senior Centers, the Aging and Disability Resource Centers (provided through regional independent living centers), State SeniorCare Office, and State Care Coordination and Education grants. State grant funds from The Alaska Mental Health Trust Authority (AMHTA), the U.S. Administration on Aging and State of Alaska general funds are used to fund projects offered through private non-profits, tribal and government entities.

Assessment: Assessments are completed under the Medicaid Waiver Program, the Medicaid Personal Care Attendant Program, the Medicaid Long Term Care Program and grant funds from the MHTA and the State of Alaska. These assessments are used to access services and to assist in developing a plan of care for the individual. This service is provided by private non-profits, for profit, tribal and government entities.

Medical Services: This includes any medical treatment for individuals with ADRD by health care professionals or paraprofessionals: i.e., Community Health Aides (CHA's), Certified Nursing Assistants, Registered Nurses (including Public Health Nurses), Physicians Assistants, Nurse Practitioners, and Physicians. Treatment is provided in patients' homes, in health clinics, private provider offices, hospitals and nursing homes.

Pharmacy Services: This includes medications for both physical and mental health needs of seniors. The Medicaid Personal Care Assistance program provides medication management for those who qualify with physical needs. State and federal funds are provided on a limited basis for this service through an Anchorage Senior Center and Mental Health Trust Authority funded grant in Southeast.

Care Coordination: This service makes available an "expert" who is available to navigate the system of care a senior receives through the Waiver or other services. The Care Coordinator works with the senior and her Caregivers to establish a Plan of Care and helps assure that services are delivered adequately to their client. These services are provided by private non-profits, for profit, and tribal entities.

Personal Care Attendants: Personal Care Services are designed to assist seniors in need of assistance with Activities of Daily Living (e.g. bathing, eating etc.) in their own homes. This service provided through Medicaid can be utilized in two distinct ways: Agency

Based services allow for a certified provider to manage the hiring and supervision of a Personal Care Attendant for a senior while Consumer Directed PCA allows for that attendant to be hired and supervised by the senior or their legal representative receiving the services with minimal assistance from an agency.

Chore Services: These are housekeeping and other services in a senior's own home. This program is both a Medicaid Waiver and grant program with funding from the state of Alaska and the U.S. Administration on Aging. Providers of all types offer these services.

Respite Services: Relief to a primary Caregiver in order to reduce caregiver stress is the primary purpose of this service. This service provided under the Medicaid Waiver, U.S. Administration on Aging - National Family Caregiver Program and state grant programs. Providers of all types offer these services.

Adult Day Services: Adult day Programs offer facility based programs, which provide recreational, health and social opportunities for seniors who are frail or experience ADRD. These programs are funded through State of Alaska funds and the Medicaid Waiver programs.

Congregate and Home Delivered Meals: These programs offer one third of the recommended daily allowances (RDA) for adults. Congregate meals are provided in senior centers and schools throughout the state. Home Delivered meals are provided for those seniors unable to easily leave their homes. These programs are provided by private non-profits, for profit, tribal and government entities through the Medicaid Waiver, U.S. Administration on Aging and State of Alaska funds.

Assisted Transportation: Assisted Transportation services are those, which take a senior from their home to appointments and back with door-to-door assistance. Transportation services are provided through the U.S. Administration on Aging, State of Alaska grant funds and the Medicaid Waiver programs through private non-profits, for profit, tribal and government entities. These services include assisted and unassisted rides.

Environmental Modifications: Refers to converting or adapting the environment to make tasks easier, reduce accidents, and support independent living for frail seniors and/or individuals with disabilities. Examples of home modification include: lever door handles that operate easily with a push; handrails on both sides of staircase and outside steps; ramps for accessible entry and exit; walk-in shower; grab bars in the shower, by the toilet, and by the tub.

Specialized Medical Equipment and Supplies: Specialized equipment and supplies include devices, controls, or appliances specified in the plan of care which enable clients to increase their ability to perform activities of daily living, or to perceive, control or communicate with their environment.

Family Caregiver Programs: These programs offer a wide range of services for family caregivers of seniors with the focus solely on the caregiver's needs. The U.S. Administration on Aging funds programs, which are designed to support Caregivers of seniors recognizing their unique role in the continuum of care. Grants are made to private non-profits to execute these programs.

Legal Service: Legal services for seniors consist primarily of guardianships and other minor legal problems. Through funding from the U.S. Administration on Aging and the State of Alaska, a provision of legal services is provided for seniors and their caregivers through Alaska Legal Services Corporation.

Assisted Living Homes: Assisted Living homes provide 24-hour care to seniors in a non-institutional setting outside a senior's home.Assisted Living homes are operated by private non-profits, for profit, and tribal entities using funds from the Medicaid Waiver Program and the State of Alaska grant funds. These homes provide twenty-four hour care for seniors and others in non-institutional settings often in or near the seniors community.

Pioneers' Homes: Located in six communities (Sitka, Ketchikan, Juneau, Anchorage, Palmer and Fairbanks) the Alaska Pioneers' Homes provide up to 600 beds of assisted living services for seniors in Alaska. Open to any senior over 65 years of age these homes are funded through the Medicaid Waiver and State of Alaska funds and operated by the Department of Health and Social Services. They have developed a specialty in serving those people who experience ADRD as well as other frail seniors. They have a Registered Nurse on site 24 hours a day and provide a centralized pharmacy, which includes a high level of medication oversight.

Nursing Homes: Skilled Nursing Facilities provide intensive services for those at the highest level of care. Funded through Medicaid they offer both short and long-term placements for senior who require significant nursing interventions each day. In many cases, through Medicare funding these facilities provide for rehabilitation services for senior returning to their homes from acute hospitalizations.

IV. Examples of Current Initiatives, Projects and Activities That Fill Service Gaps

One aim of *Moving Forward* and its related initiatives is to provide decision makers with appropriate data regarding issues that impact Trust beneficiaries. To the extent data is available or can be developed through better data collection and analysis, progress is measured for these efforts. A key strategy has been to work with partners on projects. Successful partnerships expand and enhance the resources of the Department of Health and Social Services and The Trust and further the goal of shared and integrated approaches to bettering the lives of Trust beneficiaries. Initiative efforts are largely directed toward system change. Following are examples of current initiatives, projects and activities that, in addition to the extensive day-to-day activities of the Department and The Trust, work to create system change and target improved services for Trust beneficiaries.

System Strategies

Over the last few years, The Trust and DHSS have focused efforts in six areas: prevention, integration of services, infrastructure development, workforce development, employment, and public awareness. The emphasis has been to alter the systems that provide services, and organize them in more effective and efficient ways that better meet needs, while promising cost savings in the future. Increasing public acceptance of Trust beneficiaries through education is a long-term effort to improve their lives.

Below are some examples of projects that focus on changing systems through prevention, integration, infrastructure development, workforce development, employment, and public awareness.

Prevention

The federal Substance Abuse and Mental Health Services Administration defines prevention as:

"A proactive process that empowers individuals and systems to meet the challenges of life events and transitions by creating and reinforcing conditions that promote healthy behaviors."

Mental health and substance abuse prevention activities for children and youth focus on building emotional resiliency and adding positive influences and protective factors to children's lives. Prevention includes not only interventions that occur before a problem occurs, but also interventions that prevent behaviors from becoming more severe, relapse and secondary conditions. Early intervention can often keep children's emotional and developmental disorders from becoming more severe.

Community-based Suicide Prevention and Rural Human Services

In 2004 (the most current year with official national data), Alaska had the highest suicide rate in the United States. Suicide was the 11th leading cause of death in the United States for all ages and third among the young. During that same period in Alaska, suicide was the fifth leading cause of death for all ages and second for those under age 50. The distribution of suicide by ethnicity shows a greater proportion of Alaska Natives taking their own life than the Caucasian or "other" racial categories. Although Alaska Natives comprise 16% of the population, they accounted for 39% of the suicides. And, the majority of suicides are occurring among our young people ages 20-29 years of age.[20, 41]

To better address this reality, DHSS established two programs aimed at rural Alaska and at suicide prevention and early intervention. The Community-based Suicide Prevention program provides small rural Alaska communities with the resources to take ownership of community-driven solutions to high numbers of suicides, attempted suicides, depression and alcohol use. In fiscal year 2007, over 25 communities received a comprehensive behavioral health prevention grant, with a focus on suicide prevention. Recognizing that suicide is often associated with overall mental health and alcohol and other drug use, the department requested that communities look at suicide from a holistic perspective. The goal is to integrate with other programming to reduce drug and alcohol use, increase connectedness and resiliency and to better recognize the signs of suicide.

In an effort to increase the number of trained human service paraprofessionals in our most rural and remote communities, the Rural Human Services Systems (RHSS) project, a partnership between the DHSS Division of Behavioral Health and the University of Alaska Fairbanks, Rural Human Services program, trains, hires, develops and mentors local providers in communities across Alaska. The goal of "a counselor in every village" has not yet been reached, but the number of students who have completed their Rural Human Services certification and have returned to their villages as paraprofessional counselors grows each year. Through RHSS funding, 15 rural agencies receive funding to train and employ counselors in more than 100 villages across the state. These individuals serve as a community resource, a first responder, a referral source and often, the only available resource in a community dealing with suicide, substance abuse, domestic violence, child abuse, delinquent youth and more. The Department of Health and Social Services requested and received an increment of $550,000 in fiscal year 2007 to add ten additional human service counselors statewide. With this additional funding, the Division of Behavioral Health was able to increase funding to some existing programs to serve more villages, and add two new programs through Copper River Native Association and Cook Inlet Tribal Council, Inc.

Comprehensive Fetal Alcohol Syndrome Project

Fetal alcohol spectrum disorders (FASD) are one of the most common causes of mental retardation, and the only cause that is entirely preventable. FASD refers to all those conditions caused by prenatal exposure to alcohol, including fetal alcohol syndrome (FAS). FAS is a medical diagnosis defined by the presence of specific growth and nervous system abnormalities and other factors. Receiving an early, comprehensive diagnosis that looks at growth deficiencies, facial dysmorphology, central nervous system

functionality and maternal history of alcohol abuse provides a complete picture of the level of disability, the impaired functionality and the overall interventions and accommodations that will benefit the individual. This is the first and most important intervention—from a comprehensive diagnosis, a clear case plan can be implemented and service delivery needs can be better coordinated.

FASD is found in all races and all socio-economic groups – wherever women drink alcohol, FASD exists. With the right diagnosis, support and understanding, many individuals with FASD can live happy and full lives.

Alaska's Comprehensive Fetal Alcohol Syndrome Project is an example of an effort to prevent a developmental disability, to improve services for individuals with an alcohol-related disability and to enhance alcohol treatment services for women at risk of drinking alcohol during pregnancy. With state and federal funds, the Alaska FAS Project developed community-based teams that diagnose and refer children for services, developed a multimedia public education campaign to raise awareness about the danger of drinking alcohol during pregnancy, and improved training for all service providers in Alaska to better understand and serve affected individuals and their families. Alaska's FAS Project has enhanced the state's surveillance of alcohol-related births; thereby improving the state's data related to FAS prevalence rates.

- In fiscal year 2007, the Division of Behavioral Health continued funding for 20 community-based grants awarded to local nonprofit organizations across Alaska to provide services related to individuals, families and communities impacted by FASD. These grants focus on FASD prevention, training and educational services, improved services for individuals affected by FASD, diagnostic services, and treatment services for women at risk for giving birth to a child affected by prenatal exposure to alcohol.
- Since March of 1999, approximately 1,000 diagnoses have been completed by 13 Diagnostic Teams from Fairbanks to Ketchikan, providing earlier and more comprehensive assessments for those children, youth and adults who were pre-natally exposed to alcohol, causing permanent learning, behavioral, and neuro-developmental disabilities. Through early and comprehensive diagnosis, children and youth have more opportunities for services that will increase their quality of life and their ability to be healthy, productive adults.
- Two curricula were developed to give Alaska service providers (including educators, mental health clinicians, health care providers, and correctional officers) current, consistent and scientifically-based information about the affects of alcohol on a developing fetus, the impact of alcohol on the central nervous system, and the resulting disabilities. Over 50 Alaskans, representing Alaska geographically, ethnically and across various disciplines, have been trained and certified to provide training with these two curricula.
- In December 2006 the DHSS received a five-year Medicaid Waiver Demonstration Project to improve services to young Alaskans ages 14-21 with co-occurring diagnoses of SED and a FASD. This Demonstration Project will allow

Alaska to begin developing "practice to research" service delivery approaches that will improve the long-term outcomes for youth with these diagnoses.

Medicaid Disease Management Program

Based on input from the National Governors Association Chronic Disease Policy Academy, a steering committee of top Alaska Department of Health and Social Services policy makers has been convened to direct the development of a Medicaid Disease Management (DM) Program. The DM program is a system aimed at coordinated health care interventions and communications for populations with chronic conditions. DM supports the provider-patient relationship and plan of care and emphasizes prevention utilizing evidence-based practice guidelines and patient empowerment strategies. A critical component of DM is evaluating strategies designed to optimize both clinical and economic outcomes.

The steering committee has worked with DHSS staff to analyze Medicaid claims data, identify target populations, and begin designing a DM program. The committee will develop a request for inclusion in the Department's FY 2009 budget. Within the next fiscal year, the steering committee will seek approval from the Center for Medicare and Medicaid Services for their program, and will develop a communications plan for engaging Medicaid clients and providers, develop an evaluation plan, and issue a Request for Proposals to secure a DM vendor.

The Strategic Prevention Framework

The Division of Behavioral Health, Prevention & Early Intervention Services has begun using Strategic Planning Framework from the SAMHSA Center for Substance Abuse Prevention. The purpose of the framework is to build the capacity of states, Native organizations, and communities to decrease substance use and abuse, promote mental health, and reduce disability, co-morbidity and relapse related to mental and substance use conditions.

The Strategic Prevention Framework (SPF) utilizes the following five-step process:

Assessment: *Profile population needs, resources, and readiness to address the problems and gaps in service delivery.* Communities must accurately assess their substance abuse-related problems using epidemiological data provided by the State as well as other regional and local data.

Capacity: *Mobilize and/or build capacity to address needs.* Engagement of key stakeholders at the State and community levels is critical to plan and implement successful prevention activities that will be sustained over time.

Planning: *Develop a comprehensive Strategic Plan.* Communities must develop a strategic plan that articulates not only a vision for the prevention activities, but

also strategies for organizing and implementing prevention efforts in their community

Implementation: *Implement evidence-based prevention policies, programs and policies and infrastructure development activities.* Similarly, local stakeholders will use the findings of their needs assessments to guide selection and implementation of policies, programs and practices proven to be effective in research settings and communities.

Evaluation: *Monitor process, evaluate effectiveness, sustain effective programs/activities, and improve or replace those that fail.* Ongoing monitoring and evaluation are essential to determine if the outcomes desired are achieved and to assess program effectiveness an l service delivery quality.

Integration

Behavioral Health Integration Project (BHIP)
(http://hss.state.ak.us/dbh/system_redesign/service_delivery_system_headlines.htm)

The DHSS Division of Behavioral Health has been integrating the two former DHSS systems that provided community mental health and community drug and alcohol treatment into a single behavioral health system. In addition the BHIP project has worked extensively to develop co-occurring capability (services for individuals with both mental health and substance use disorders) throughout the behavioral health service system. This project, broad in scope, aims to transform the Alaska behavioral health services system. The goal of the BHIP is to develop a behavioral health services system that is welcoming, accessible, integrated, comprehensive and continuous, at a client, consumer, clinician, program and system level.

More recently, the focus of the BHIP project has been to finalize the integration of regulations for the system of care. After a significant effort to obtain input from providers and other stakeholders, the DBH is current engaged in the internal process of regulations development that will culminate in adoption of regulations to govern the Behavioral Health Service system.

Early Childhood Comprehensive Systems (ECCS) Early Childhood Mental Health Cross-Systems Workgroup
(http://www.hss.state.ak.us/ocs/childplan/default.htm)

Over the last year the ECCS (Early Childhood Comprehensive Systems) Early Childhood Mental Health Cross-Systems Workgroup developed recommendations to improve accessibility to appropriate, high quality mental health services for young children birth to five years of age. They are beginning the process of translating these recommendations into regulatory and policy changes.

The ECCS Workgroup is developing a viable model for mental health consultation for professionals who work with young children in Alaska. They are piloting a model over the next year which includes billing for Medicaid Administrative reimbursement. This will help build the number of Alaska's mental health practitioners who are more skilled in working with early childhood mental health issues and interventions. The ECCS Workgroup supported a two day "early childhood mental health training" for a cohort of mental health clinicians, early interventionists and child protection staff from across the state. The mental health clinicians and early interventionists will continue to participate in a "learning network" via monthly conference calls with a consultant with expertise in this area. This effort will continue and be expanded to more professionals over the coming year.

Health Care Strategies Planning Council

(http://www.hss.state.ak.us/hspc/)

A new Health Care Strategies Planning Council was appointed by Governor Palin to develop a statewide plan to effectively address the issues of access to, and cost and quality of, health care for Alaskans. The intent is that the council's development of a health care action plan should serve to educate all Alaskans about the myriad of public policy choices regarding health care issues and engage both governmental agencies and the private sector in finding solutions to these problems.

The council has been directed to prepare and submit to the governor and the Legislature, by January 1, 2008, a health care action plan which includes the following: (1) a description of the current health care system in Alaska; (2) an inventory and analysis of all existing private and public health care plans, reports, and initiatives in Alaska; (3) short-term and long-term statewide strategic plans designed to improve health care access, cost, and quality within the next ten years; and (4) performance measures and accountability mechanisms to provide policy makers with tools to assess the success of the strategic plans over time. In addition, the council will convene a health care conference to take public testimony on the issues of health care access, cost, and quality, and to serve as a forum to educate all Alaskans on health care issues.

The commissioner of the Department of Health and Social Services is chairing the council and the Department is providing administrative support.

Infrastructure Development

Affordable Housing Focus Area

http://www.mhtrust.org/index.cfm?fa=documents_meet-search&doctype=Focus%20Areas%20-%20Affordable%20Appropriate%20Housing

Trust beneficiaries have many unmet housing needs; therefore the Alaska Mental Health Trust Authority has identified affordable housing as a priority area for funding and advocacy. Safe, decent, affordable, accessible and appropriate housing is often the key for Trust beneficiaries in maintaining a healthy lifestyle and participating in rehabilitation

and recovery activities. The statewide shortage of affordable, safe, accessible, and appropriate housing disproportionately affects Trust beneficiaries due to the challenges associated with disabling conditions and the lack of opportunities for economic advancement. Some beneficiaries require long term supportive living situations or accommodations to meet special needs and others simply require a subsidy for a period of time to afford permanent, stable housing.

The following strategies comprise the Affordable Housing focus area's approach to increasing the number of safe, affordable housing options available to Trust beneficiaries:

- Policy advocacy for new funding resources (i.e. an affordable housing trust in Alaska, inclusion of supported housing in mainstream affordable housing, etc.)
- Adaptation of successful models and existing housing options in Alaska: increasing targeted support services for intensive needs populations, adapting successful models to support alcoholics in recovery, inclusion of special needs housing in community developments, etc.
- Increasing capital resources for supportive housing
- Increasing options for housing preservation, i.e. maintaining successfully housed Trust beneficiaries in homes as long as possible through temporary mortgage assistance, increasing options for financial literacy, etc.
- Increasing the availability of long term care supports and community based services for those beneficiaries who are at risk of institutionalization.
- Increasing the availability of technical assistance through the state's Department of Health and Social Services for development and maintenance of safe, affordable housing at the community level.

The Trust is working with several housing development groups, including Tlingit and Haida Housing Authority and Cook Inlet Housing Authority, to determine the best method for supporting beneficiaries in affordable housing. Successful projects have been supported through the Kenai Peninsula Housing Initiatives, Valley Residential Services and Anchorage Housing Initiatives.

The Bridge Home program is an example of an early success for The Trust's Affordable Housing focus area. This "housing first" program provides housing subsidies and supports to individuals with severe mental illness who have a history of repeated episodes of institutionalization. Modeled on successful supportive housing projects in Hawaii, Connecticut and New York, the Bridge Home Program assists clients to stabilize in their own homes and eventually become eligible for HUD Section 8 vouchers and a semi-independent lifestyle. As a result of the Bridge Home program, clients have decreased their rates of incarceration. Of the 31 Bridge Home clients with a history of incarceration during the pre-program period, 29 (94%) decreased their rates of incarceration and 2 (6%) increased. The clients who had no history of arrests during the pre-program period were also not arrested during the program.

Alaska Council on Homelessness
(http://www.ahfc.state.ak.us/homeless/homeless.cfm)

The Alaska Council on the Homeless was initially established in April 2004 to develop a statewide action plan addressing homelessness in Alaska. The plan, *Keeping Alaskans Out of the Cold,* was completed and submitted in October 2005. Included in its recommendations was the appointment of a steering committee to assist the governor and the legislature to develop an affordable housing trust. The steering committee completed its work in 2006 and the current council has recommended that the Alaska Housing Trust Fund be created within the Alaska Housing Finance Corporation (AHFC) under statute.

The Alaska Council on Homelessness consists of members appointed by the governor. The council will assist with development of the Alaska Housing Trust Fund; annually evaluate housing needs and priorities to establish a statewide homeless action plan and recommend to the AHFC Board of Directors the allocation of money in the fund to implement the plan; monitor and review implementation of the statewide homeless action plan; and annually report to the governor on how state resources, in addition to the fund, may be used to end homelessness.

Alaska Housing Trust
http://www.akhousingtrust.org/index.cfm?section=about&page=overview

Under its Affordable Housing focus area, the Alaska Mental Health Trust Authority has been engaged in advocating and planning an Alaska Housing Trust. In May and June 2007, major funding partners, The Trust and Rasmuson Foundation, granted $1 million each to pilot the project. The Municipality of Anchorage also plans to allocate portions of its federal grant resources to leverage these funds in the pilot program. The housing focus area workgroup will play a major role in developing supported housing projects for this trial run.

Alaska Policy Academy on Homelessness
(http://www.hrsa.gov/homeless/State/ak.htm)

The goal of the Alaska Policy Academy on Homelessness is to enable Alaskans to live in appropriate and affordable housing as close to their community of choice as possible by: (1) promoting locally delivered collaborative family-centered services; (2) increasing collaboration and coordination to end homelessness; (3) increasing safe and affordable housing stock; and (4) ensuring integrated planning for homelessness in Alaska.

Bring the Kids Home
(http://www.mhtrust.org/index.cfm?fa=documents_meet-search&doctype=Focus%20Areas%20-%20Bring%20the%20Kids%20Home)

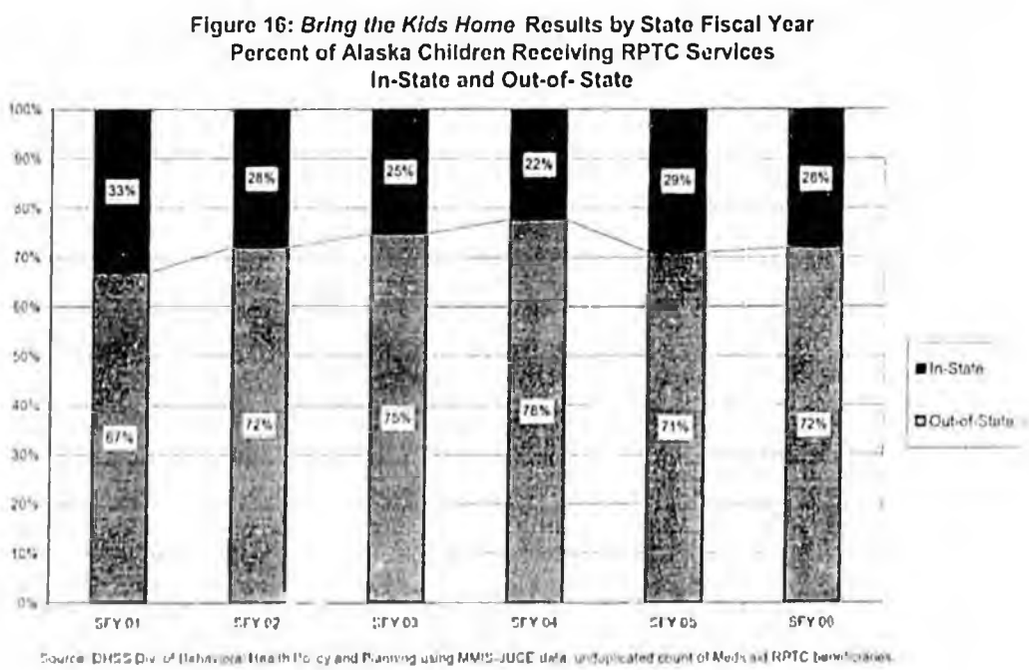
During the period of 1998 – 2004, the children's behavioral health system in Alaska became increasingly reliant on institutional care - Residential Psychiatric Treatment

Center (RPTC) care for treatment of severely emotionally disturbed youth. Out-of-state placements in RPTC care grew by nearly 800%. At any given time, approximately 350-400 children were being served in out of state placements. Alaska Native children represent 49% of the custody children sent to out of state placements and 22% of the non-custody children sent to out of state placements.

The Department of Health and Social Services, in collaboration with the Alaska Mental Health Trust Authority initiated the "Bring the Kids Home" (BTKH) Initiative in 2004, to return children being served in out-of state facilities back to in-state residential or community-based care. The initiative intends to reinvest funding now going to out-of-state care to in-state services and develops the capacity to serve children closer to home. With financial support, this initiative will focus on successfully building upon the existing infrastructure to treat youth in their community, region and state.

The scope of this project requires that four levels of the system of care must be addressed concurrently: community, regional, in-state, and out-of-state care. Further, there are issues that are applicable to the overall system of care, i.e. policy development, management of authorization, utilization, and enhanced care coordination, workforce development, funding, expansion of facilities and infrastructure, and expansion of services.

Figure 16: Bring the Kids Home Results by State Fiscal Year -Percent of Alaska Children Receiving RPTC Services In-State and Out-of- State



Source: DHSS Div. of Behavioral Health Policy and Planning using MMIS-JUCE data, unduplicated count of Medicaid RPTC beneficiaries.

Dental Care Access

The Trust and DHSS are committed to improving access to dental care for all Trust beneficiaries. The Trust is participating with the Alaska Dental Access Coalition (ADAC) which is focusing on policy areas of workforce, finance and reimbursement, service availability and access and prevention of oral diseases. The coalition serves in an advisory capacity to the DHSS Oral Health Program supported by a grant from CDC.

The ADAC is a multi-agency coalition with broad support and participation on dental access issues. The ADAC is chaired jointly by The Trust and the Rasmuson Foundation, and staffed by DHSS. After successfully advocating for the new adult dental Medicaid benefit (implemented April 1, 2007), the coalition is committed to tracking the progress of the adult dental Medicaid services program and preparing to advocate for the renewal of the program in FY2009 when the enabling legislation has a "sunset" provision. Additional work is proceeding in all of the focus areas outlined in the ADAC activities.

Disability Justice – Justice for Persons with Disabilities Focus Area

Beneficiaries of the Alaska Mental Health Trust are at increased risk of involvement with the criminal justice system both as defendants and as victims. Limitations and deficiencies in the community emergency response, treatment, and support systems make criminal justice intervention the default emergency response to the conditions and resulting actions of many Trust beneficiaries. The Trust's Justice for Persons with Disabilities Initiative began in April 2004. A collaborative group, including The Trust, advisory boards, state and local government agencies, the court system, law enforcement, consumers, advocacy groups, community behavioral health providers, and others, have developed and are implementing the following several strategies to address this issue:

- increase training for criminal justice personnel;
- sustain and expand therapeutic court models and practices;
- improve continuity of care for beneficiaries involved with the criminal justice system;
- increase capacity to meet the needs of beneficiary offenders with cognitive impairments;
- develop mechanisms to address the needs of Trust beneficiaries who are victims;
- develop community-based alternatives to incarceration for beneficiaries;
- develop a range of housing options to provide for varying needs of beneficiaries involved at different stages of criminal justice system; and
- evaluation of the initiative's impact to improve justice for beneficiaries.

Examples of Justice for Persons with Disabilities Focus Area Projects:

Judicial and legal training. A collaborative effort among The Trust, Alaska Court System, Alaska Bar Association, and the Anchorage Bar Association to provide education and training to assist judges, lawyers, and other legal professionals understand and more effectively handle cases involving persons with mental

disabilities. A six session continuing legal education (CLE) curriculum has been developed and implemented covering a variety of topics from an overview of mental health disorders to effectively communicating with persons who experience a mental disorders.

Crisis Intervention Team (CIT) training. A 40 hour training in which law enforcement personnel are educated about mental illnesses and other disabilities, medications, suicide and crisis intervention, active listening skills, de-escalation techniques, empathy, and respect. The CIT training recognizes the need for a specialized response to those who experience mental illness and other disabilities. It is a community based partnership between consumers, law enforcement, NAMI (National Alliance on Mental Illness), and community treatment providers. All have joined together to recognize the common goals of safety, service, and understanding. Currently, CIT teams exist with the Anchorage and Fairbanks police departments.

Therapeutic court principles and models. Therapeutic court principles and models focus on appropriately diverting Trust beneficiaries with mental disabilities charged with misdemeanor offenses from incarceration and into appropriate community treatment and services, preventing further contacts with the criminal justice system. There are therapeutic mental health and drug courts operating in communities throughout the State (Anchorage, Bethel, Juneau, Ketchikan, and Palmer).

Discharge planning from corrections into the community. The Department of Corrections is working with state, federal and community partners to coordinate and develop a pilot re-entry transitional services model for Trust beneficiaries being released from correctional institutions to the community. The *APIC transitional model* (Assess, Plan, Identify, and Coordinate), cited as a best-practice in the 2004 President's *New Freedom Commission Report on Mental Health*, is being adapted to meet Alaska's needs. The goal of the APIC re-entry pilot is to connect Trust beneficiaries with services prior to release and to provide intensive supports upon their initial release, to both increase their chances of success in the community and to reduce the potential for re-incarceration. The communities targeted, but not confirmed for this pilot include: Anchorage, Palmer and Wasilla, Fairbanks, and Juneau.

Victimization. Trust beneficiaries are at increased risk because they are more vulnerable to financial, physical, and sexual victimization and exploitation. However, the number of Trust beneficiaries who are victims of crime each year is unknown because victimization of persons with disabilities too often goes unrecognized and unreported or, if reported, not pursued because of the perceived limitations or lack of credibility of the victim. The University of Alaska's Center for Human Development with funding from The Trust is gathering in-state data on these issues to define the scope and extent of the problem.

Division of Juvenile Justice System Improvement Initiative

For the past several years through its system improvement efforts, the Division of Juvenile Justice (DJJ) has enhanced the services provided to juvenile offenders and families who are also Trust beneficiaries. Strategies put in place by DJJ to address youth with behavioral health issues range from services that are community-based, to facility detention and treatment services, to re-entry or aftercare services. These include, for example, non-secure shelters for youth with immediate behavioral health problems and alternatives to detention such as electronic monitoring and community detention. Strategies also include therapeutic services with the addition of mental health clinicians in several facilities and substance abuse counselor certification for field and facility staff across the state. Aggression Replacement Training, proven to be effective in increasing pro-social behaviors and reducing recidivism for youthful offenders, has been implemented statewide. In addition, DJJ is partnering with the Court and other stakeholders to develop a pilot mental health court in Fairbanks. Upcoming activities include the integration of the statewide DJJ facility suicide prevention policy into a statewide policy for residential providers; and the integration of three new mental health clinician positions into DJJ core services along with ensuring DJJ clinical practices are consistent statewide and comport with existing Alaska protocols supported by the Department of Health and Social Services.

The Healthy Body, Healthy Brain Campaign

The Healthy Body, Healthy Brain Campaign is an education and public awareness effort based on recent research indicating that many cases of Alzheimer's Disease and Related Disorders (ADRD) can be prevented by a healthy lifestyle that includes physical activity, good nutrition, weight management, regular socializing, and intellectual tasks such as puzzles and games. An ADRD-preventive lifestyle has much in common with the habits already associated with avoiding other chronic diseases such as diabetes, heart disease and cancer. However, people often fear the mental losses of ADRD more than they fear a heart attack, an amputation, or a round of chemotherapy. As a motivator, the prospect of developing ADRD may be particularly effective.

This prevention and health promotion project will use evidence-based social marketing techniques to reach middle-aged and older adults (directly and through workplaces, senior centers, and other organizations with which they're connected) to maximize the awareness of the public as well as health care and social services professionals of the importance and the effectiveness of a healthy, balanced lifestyle in preventing ADRD. The Healthy Body, Healthy Brain Campaign, funded by The Trust, is to be initiated in FY 08 by the Alaska Commission on Aging and the Division of Public Health.

Performance Management System Project

(http://www.hss.state.ak.us/dbh/perform_measure/perfmeasuredefault.htm)

The DHSS Division of Behavioral Health "Performance Management System" is developing a continuous quality improvement process to guide policy and decision-

making for improving the behavioral health of Alaskans. The Performance Management System has three broad components: the service delivery system, broad population planning, and DBH management indicators.

In the pubic service delivery system, the performance measures address whether the services are of high quality; whether the behavioral health system is efficient, productive, and effective; and whether services produce the desired impact on the quality of life of consumers. To support behavioral health planning for the broader population, the project will address the following questions: (1) are Alaskans who need services getting them, and able to get them conveniently; (2) do Alaskans with behavioral health disorders live with a high quality of life; and (3) are efforts taking place to prevent or lessen problems that result in consumers needing services. The DBH Management Indicators component will address performance indicators useful for the management of the service delivery system, including accountability and documented outcomes to provide transparency in the use of public funds.

These performance measures feed into a continuous quality improvement process to inform and improve the delivery of effective, high quality services. Provider organizations may use the DBH performance measures and indicators for planning and evaluating performance improvement activities; for soliciting new funding; or for reallocating resources.

Traumatic Brain Injury Project

The incidence rate of identified Traumatic Brain Injuries (TBIs) in Alaska is 28% higher than the national rate. Alaska's Traumatic Brain Injury Project is focusing on the cognitive, emotional, and behavioral manifestations of traumatic brain injury. In partnership with The Trust, the Department is developing infrastructure to provide for culturally competent treatment and rehabilitation services specific to TBI survivors who experience cognitive, emotional, and behavioral manifestations as a result of head trauma. The Alaska Screening Tool screens all admissions into the public behavioral health system for possible TBI. The project has also sponsored numerous training events to assist the behavioral health system to identify TBI, make referrals, and provide basic services to TBI survivors, and has set up a management information system to eventually track the course of those interventions. The State was also recognized in 2006 for system innovation and included in a Neurobehavioral Handbook in 2007 by the National Association of Head Injury Administrators (http://www.nashia.org/)for these accomplishments. Regardless of these accomplishments, the need for specialized services in Alaska remains high.

The Alaska Brain Injury Network Inc. (www.alaskabraininjury.net) serves as the TBI Advisory Board as well as an information and referral source for Alaskans with brain injuries needs. ABIN works with the Alaska Mental Health Trust Authority and the Department of Health and Social Services to recommend and implement culturally competent and statewide brain injury services.

Trust Beneficiary Projects

Trust beneficiaries and their families are growing increasingly interested in accessing services that are provided by fellow consumers/clients and family members. Such services can create a sense of empowerment and promote recovery, and consumer choice often enhances service quality and sustainability. Trust beneficiary projects can be very cost effective and meaningful to participants. Consumers, or the 'end users of services', have been key to innovations in the state's delivery system by conceptualizing, managing, and improving programs by and for themselves.

The Trust's initiative for beneficiary projects is a method to assist beneficiaries in developing and improving services, while informing the social services field of promising practices in this area. The initiative's goals are:

- ensuring that Trust beneficiary initiated and managed activities are safe, effective, and sustainable;
- providing a viable avenue for organized advocacy that is rooted in community needs and addresses existing service gaps; and
- providing a technical assistance entity to support Trust beneficiary initiatives in data collection, analysis and training activities.

Workforce Development

Trained, experienced professionals are essential to providing the specialized care needed by people with cognitive or developmental disabilities and their families. Barriers to recruitment and retention in Alaska include workers' stress, isolation, low pay, limited benefits, burnout and turnover. Adequate pay, training, and supervision assure better quality care and a more stable service delivery system. In order to provide appropriate services to Trust beneficiaries, an adequate and competent workforce must be recruited, trained, and retained.

Workforce Development Focus Area

The Trust, in collaboration with the Alaska Department of Health and Social Services, other state agencies, the University of Alaska, advisory boards, service providers and Trust beneficiaries and their families, are working to develop a prioritized plan for workforce development for behavioral health and other beneficiary service provider areas. In 2006 and 2007, workgroups on recruitment, retention, and training and education developed action plans for the upcoming fiscal year.

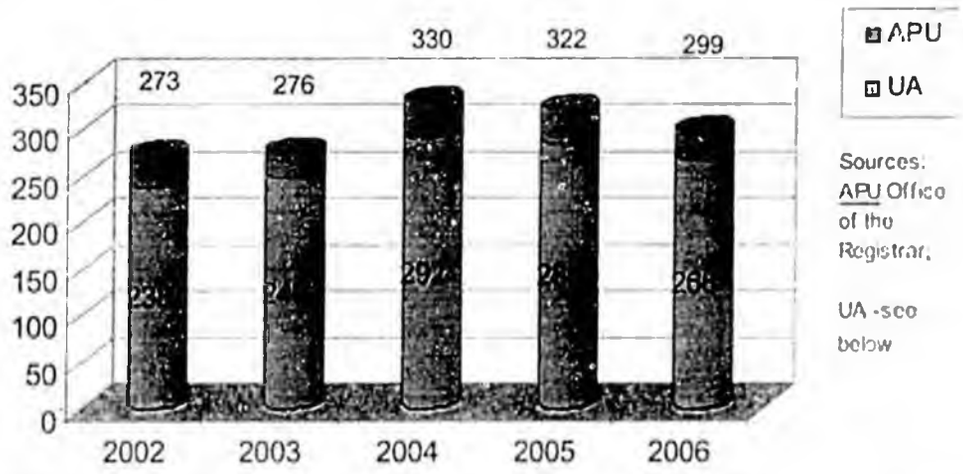
Some examples of proposed activities to increase recruitment, retention, and training for professionals serving Trust beneficiaries include: 1) implement a grow-your-own initiative focused on youth including activities such as job shadowing and behavioral health career clubs, 2) develop marketing strategies within Alaska for beneficiary area service careers in order to recruit broader, non-traditional populations (e.g., Alaska Natives, seniors, retired persons, and persons with disability), 3) provide technical

assistance to and track the progress of 6-10 service providers interested in increasing retention efforts, 4) create a regional training collaborative that provides community-based training that complements other education and training efforts in the state. In addition to generating strategies, the plans assign responsibility for implementing and funding the strategies and for measuring the results.

In addition, DHSS and The Trust are working with University of Alaska and tribal organizations to develop certification standards for behavioral health aides, in order to boost competent and accessible care in rural Alaska communities.

Figure WD-1: Behavioral Health Program Degrees and Certificates Awarded at Alaska's Universities

Figure WD-1
Behavioral Health Program Degrees and Certificates Awarded at Alaska's Universities

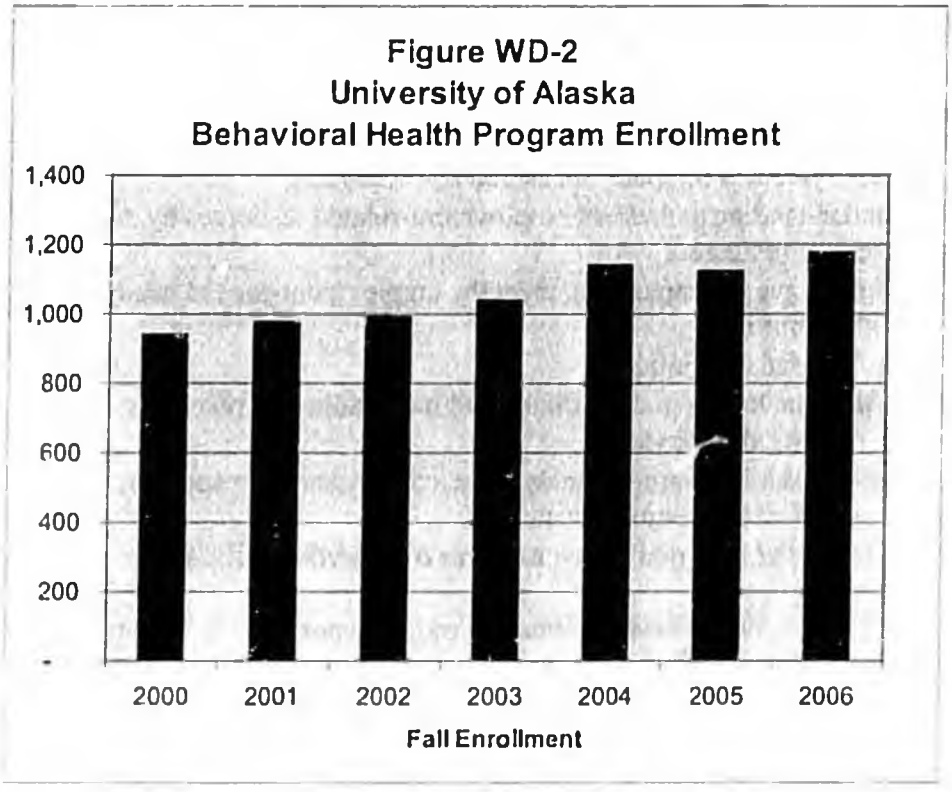


Degrees and certificates included in this data. University of Alaska: Certificate - Developmental Disabilities, Disability Services, Human Service Technology, Rural Human Services; AAS - Developmental Disabilities, Disability Services, Human Services; BA - Community and Change, Human Services, Social Work; BA/BS Psychology; MS - Clinical Psychology, Counseling Psychology. Alaska Pacific University: Counseling Psychology, Human Services, Psychology.

UA Source: UA Information Systems: Banner SI reporting extracts. Prepared by Statewide Institutional Research and Planning (http://www.alaska.edu/swoir/)

Alaska Pacific University: www.alaskapacific.edu

Figure WD-2: Enrollment in Behavioral Health Programs at University of Alaska



Source: Information provided by MAUs via UA Information Systems: Banner SI reporting extracts. Prepared by Statewide Institutional Research and Planning. (http://www.alaska.edu/swoir/)

Degrees and certificates included in this data. Certificate - Developmental Disabilities, Disability Services, Human Service Technology, Rural Human Services; AAS - Developmental Disabilities, Disability Services, Human Services; BA - Community and Change, Human Services, Social Work; BA/BS Psychology; MS - Clinical Psychology, Counseling Psychology.

Employment

Moving Forward's goal for economic security includes work opportunities for Trust beneficiaries. Being employed is a common experience that is not always shared by Trust beneficiaries. Employment enhances an individual's self respect and reduces public assistance. For many Trust beneficiaries the goal of employment may be reachable only through the assistance of others.

Alaska Works Initiative

www.alaskaworksinitiative.org

The Alaska Works Initiative is a statewide, federally-funded initiative comprised of a variety of stakeholders who are working to implement the following vision: *Alaskans*

who experience disabilities are employed at a rate as close as possible to that of the general population. Over the next four years, initiative partners will continue to implement the following eight goals:

- Work expectations and incentives are built into programs and services for people with disabilities.
- Success in employment is regularly measured and analyzed.
- Awareness, understanding and use of employment-related resources by Alaskans with disabilities are increased.
- Service providers have the capacity to meet the employment-related needs of Alaskans with disabilities
- Resources are blended and braided.
- A variety of funds including under-utilized and non-traditional resources, are being used to fund needed services.
- Job seekers with disabilities are routinely connected to needed resources, including the workforce investment system.
- Services and resources are coordinated as a part of everyday activities.

As of December 31, 2006, 1,495 individuals were served, of whom 640 or 42.8 percent secured full or part time employment.

In October 2006, the Governor's Council on Disabilities and Special Education received a three-year research and demonstration grant from the federal Office of Disability Employment Policy to increase the number of Alaskans with disabilities who are self-employed. Project goals are to:

- Update and expand resource mapping and needs assessments to identify strengths and limitations of existing resources and ascertain training, technical assistance and policy needs.
- Develop, test, evaluate and disseminate a customized self-employment model at the one-stop job centers in Anchorage, Fairbanks and southeast Alaska.
- Establish a business incubator program
- Modify and/or develop policy that facilitates permanent, systemic change that results in increased numbers of Alaskans with disabilities becoming self-employed.

It is anticipated that the following outcomes will be achieved:

- System wide assessment and identification of self-employment improvement opportunities via resource mapping (see Goal 1 above)
- Piloting and demonstration of two self-employment models (customized self-employment partnerships and business incubator) for 30 self-employed persons with disabilities (see Goal 2 and 3 above)
- Utilizing lessons learned from the pilots, development and implementation of longer term policy and training strategies to enhance Alaska's workforce system's

capacity to successfully serve people with and without disabilities so they can become successfully self-employed (see Goal 4)

Family Centered Services

DHSS's Family Centered Services project for individuals receiving Public Assistance focuses on solving personal and environmental barriers to employment and self-reliance by using a proven, national "customized employment" model. This approach is designed to increase employment options for individuals with significant barriers to employment, such as Trust beneficiaries.

The Division of Public Assistance, working closely with partner agencies including the Division of Behavioral Heath, Office of Children's Service, Division of Juvenile Justice, Division of Vocational rehabilitation and local community partners in Fairbanks and Mat-Su communities, have seen good outcomes through the use of these service techniques. Through the collaboration of the service providers and coordinated case management efforts, families have engaged in activities that have moved them towards self-sufficiency and improved quality of life.

The Division of Public Assistance anticipates expanding the family centric approach to all service areas in the state gradually over the next two to three years.

Public Awareness

The Trust, DHSS and beneficiary boards are committed to reducing the stigma associated with mental health problems, substance use disorders, developmental disabilities, age related dementias and brain injury. Efforts to educate the public will decrease this barrier to necessary care and treatment. Public education to reduce stigma also makes it easier for Trust beneficiaries to participate in community life. Learning about the prevalence of disabling conditions and the availability and effectiveness of treatment can also positively impact public policy.

Trust Coordinated Communications Campaign

Stereotypes about mental illness, addictive diseases, developmental disabilities or dementia make it harder to find work, housing and meaningful social contacts. Stigma can dissuade people from seeking care when they need it. *Moving Forward's* goal is to reduce the stigma associated with mental illness, alcohol abuse, developmental disabilities, and age related dementia. This goal is central to the Coordinated Communications Campaign, an initiative of The Trust and its advisory boards, to reduce the stigma of beneficiary disabilities and to emphasize the concept that treatment and services work. The Coordinated Communications Campaign is multi-media, including newspaper ads, posters, TV ads, movie theater ads, trading cards and radio ads.

V. Emerging Issues/Trends

The timeframe for this *Comprehensive Integrated Mental Health Plan, Moving Forward*, is 2006-2011. During that time period, it is likely that changes in leadership and policies at both the national and state levels will impact the lives of Trust beneficiaries in ways that cannot yet be quantified. More work will be done on these issues as details become clear.

Access to Primary Care for Medicare Patients

Patients in some parts of Alaska report disturbing levels of difficulty in finding primary care providers willing to see Medicare patients. Many seniors have been terminated from care by their long-standing family physicians. Doctors say that Medicare's reimbursement rates cover less than 50% of their costs of care. After a Congressional hearing held by Senator Lisa Murkowski in Anchorage in early 2007, a resolution (SJR 3) passed by the 2007 Alaska Legislature urged Congress to order a comprehensive rewrite of the Medicare reimbursement formulas.

Access to primary care affects all Trust beneficiary groups. There are a number of dual eligibles (Medicaid and Medicare) among the developmentally disabled population, and they are experiencing the same shortage of providers.

Alaska Health Information Exchange (HIE)

The State of Alaska Department of Health and Social Services *Alaska Medical Assistance Program (Medicaid Program)* is collaborating with public and private providers throughout the state to develop a more efficient and cost effective system for communication in healthcare delivery. The goal of the initiative is to coordinate a statewide health information exchange that will improve access to clinical information by both providers and patients.

The intended outcomes of the HIE pilot project are:

- *To ensure timely access to pertinent patient information* – Providers and consumers will have access to complete patient histories in real-time, facil.. ng decision support, prompt treatment, and administrative efficiencies.
- *To improve health outcomes through enhanced monitoring and reporting* – Detailed, comprehensive reports can be generated through connected databases for the purposes of quality outcomes, public health monitoring, and biosurveillance.
- *To reduce costs associated with duplicative testing and administrative processes* – Providers and payers can quickly obtain the information necessary to process claims and deliver case management.
- *To actively engage patients in the management of their healthcare* – Through

personal health records, patients can utilize network resources for health monitoring and other e-clinical services such as online scheduling, clinician messaging, and access to educational materials.

- *To establish a best practices model for statewide replicability and participation* – The pilot project will demonstrate the effectiveness of HIE and offer valuable lessons learned for future expansion.

Due to the large percentage of Alaska Natives eligible for Medicaid, the State Medicaid Program has enlisted the Alaska Native Tribal Health Consortium (ANTHC) to assist with the planning and oversight of this project. ANTHC facilitated the creation of Alaska ChartLink, a group of healthcare leaders from around the state who possess extensive experience in the planning and oversight of many statewide telehealth projects.

Alaska's Uninsured

Staff of the Department of Health and Social Services, working on the State Planning Grant on insurance coverage funded by the US Department of Health and Human Services, Health Resources and Services Administration, (2005-2007), has assembled data from many sources that show that Alaska's highly seasonal employment patterns make it difficult for workers to qualify for consistent health care coverage. Focus groups conducted in 2006 and 2007 reported that those at risk of being uninsured expected to be responsible for contributing to the cost of health care coverage, but generally could afford about $100 a month, considerably less than the cost of a health insurance policy for an individual or family.
http://www.hss.state.ak.us/commissioner/Healthplanning/planningGrant/default.htm

About 83 percent of Alaska residents are covered by health insurance (including government health coverage) at some time during the year.[1]The annual Current Population Survey indicates that employment-based health insurance accounts for coverage of more than half of Alaskans (52%), and public programs cover one third of Alaskans (Medicaid covers about 108,000, Military programs cover 84,000 people who are residents, Medicare covers nearly 56,000 Alaskans).

Young adults, especially males 18-24, are the most likely age-sex group to be uninsured. Part time and seasonal workers and the self-employed are also less likely than full-time workers to be insured. Although the majority of uninsured people are low-income, over a third are middle and higher income, and about half of the uninsured people are employed.

Smaller firms are less likely to offer health insurance than larger firms (according to state surveys of employers in 2001 and 2006, and US Medical Expenditure Panel Survey). Even the larger firms do not generally offer insurance to seasonal workers or to all part time employees.

Effects of Medicaid Rate Freeze

Providers of Developmental Disabilities and Senior Medicaid services have experienced significant cost increases related to fuel, health care, and worker's compensation in particular, as well as inflation in general. However, provider rates have been frozen since 2004. The rate freeze is impacting the financial stability of provider organizations as well as their workforce. Difficulties in recruiting and retaining quality staff in general are exacerbated by the freeze.

Emergency Preparedness

Individuals with special health care needs and disabilities are extremely vulnerable during and after an emergency or disaster. Particularly important are issues of notification, evacuation/transportation, sheltering, having access to power (i.e. for ventilators, electric wheelchairs, suctioning equipment, and refrigeration), medications, mobility equipment, and accessible information. For those who are technology dependent, being without power, durable medical equipment, medical supplies and pharmaceuticals can be life threatening. A flooded or damaged ramp may prevent evacuation of a building or home. Shelters may not be prepared for people who are deaf, people with mental illness, and those who cannot transfer onto a low-lying cot, or drink out of a cup without a straw.

Recent disasters in the Gulf Coast of the United States made evident to the American public that emergency response and recovery systems are inadequately equipped to accommodate people with disabilities and special health care needs. A national review of emergency preparedness plans in all U.S. states and 75 major U.S. cities found that none adequately addressed special needs populations. All levels of government would benefit from increased participation of people with disabilities and disability experts in the development and execution of emergency preparedness plans, training, and exercises.

Cross training among emergency and disaster preparedness professionals, organizations providing services to Trust beneficiaries, and advocates would be beneficial. Emergency responders need information about how to accommodate Trust beneficiaries, and Trust beneficiaries would benefit from learning how to be prepared for an emergency.

There have been some activities in Alaska to address emergency preparedness for special needs populations. For example, the Municipality of Anchorage started a Special Needs Registry. Also the Governor's Council on Disabilities and Special Education has included this topic in their five-year plan and will be bringing together partners to discuss next steps and increase dialogue among disability groups and emergency preparedness staff. The Department of Health and Social Services Public Health Preparedness Program is coordinating community-specific planning to address emergency preparedness throughout the state. They are providing guidance to local communities to prepare their community-specific plans. The Division of Behavioral Health is also assisting with disaster response in communities for responders as well as victims.

Emerging Addiction Research

New studies using brain imaging have confirmed that addiction is a treatable disease. Discoveries in the science of addiction have led to advances in drug and alcohol abuse treatments that help people stop abusing drugs and resume their productive lives. Alaska's drug and alcohol treatment system is not able to take full advantage of these advances because of lack of funding and provider shortages. This imposes significant long and short term costs on individuals and society.

Emphasis on Prevention and Intervention Services

Prevention of mental health problems, brain injury, Alzheimer's disease, and substance abuse includes building positive influences and protective factors into Alaskans' lives. Interventions can prevent behaviors from becoming more severe, relapse and secondary conditions. Early intervention can often keep children's emotional and developmental disorders from becoming more severe.

A growing prevalence of children with autism spectrum disorders has raised the urgency of need for early intensive intervention. Unique to this group of children is the possibility of ameliorating symptoms. Evidence-based interventions have been shown to substantially decrease the need for special education and lifelong care when averaged over the population of children with autism spectrum disorders. Alaska lacks strong intervention programs in autism, as well as a financing mechanism to pay for such services. The lifetime cost of care for a person with autism has been estimated at $3.2 million, yet early intensive intervention has been shown to decrease the lifetime cost of care by 75%. There is a need to develop and finance both an intervention program that is coordinated across service systems and a workforce to deliver the services.

Prevention and early intervention efforts are critical to minimize the financial and personal costs associated with Alzheimer's disease and related dementias (ADRD) in the future. With Alaska's senior population projected to grow at an unparalleled rate over the next 25 years, unprecedented demands will be placed on the state's long-term care system. A study of Medicaid costs by the Lewin Group (2006) projected that seniors' costs will begin to dominate Alaska's Medicaid program as the baby boomers age. Programs that encourage baby boomers and seniors to develop or maintain healthy lifestyle habits such as physical activity, good nutrition, regular socialization, and engagement in mentally challenging tasks will pay off in substantially lower health care and long-term care costs as well as greater well-being for seniors. Such programs can be implemented through workplaces, churches, senior centers, community organizations and many other partnerships.

Insurance for Behavioral Health Treatment

A national move to include behavioral treatment (mental health and substance use disorders) in health insurance coverage at the same level as physical health reflects the awareness that many physical health problems are tied to behavioral health problems. Senator Murkowski is cosponsoring the Mental Health Parity Act of 2007 on a national

level, but as Alaska looks at the structure of its funding for health care services, it is essential that we also look at the coverage available for behavioral health services in our state. Parity in behavioral health coverage has been shown to reduce both physical health care and societal costs.

Long-Term Care Strategic Plan

Alaska faces an enormous increase in the demand for long-term care as well as other services such as health care and affordable, appropriate housing. One of the recommendations of the Alaska Long Term Care and Cost Study (2006) was that the State of Alaska develop a three-to-five year statewide strategic plan for long-term care to ensure that it remains responsive to the needs of consumers, providers, and all other stakeholders. Such a plan would provide a blueprint with goals, strategies, and performance outcomes that can be used to guide the service system as it continues to grow and expand.

One factor driving the need for a strategic plan is the aging of the baby boomer generation. The number of seniors in Alaska is growing faster than any almost every other state's senior population. It is estimated that by 2030, Alaska will be home to more than twice as many seniors, including three times as many who are age 85 and older – the group most vulnerable to Alzheimer's disease and related dementias (ADRD).

Medicaid Issues

Several upcoming Medicaid issues could result in significant general fund expenditures for the State of Alaska.

Because of federal changes to the rates at which state governments and the federal government share Medicaid costs, Alaska's Medicaid costs could increase by more than $70 million per year beginning in federal fiscal year 2008. Due to intervention by Alaska's congressional delegation, the federal government will continue to pay Medicaid costs at a rate of 57 percent and Alaska will continue paying at 43 percent until federal FY 08. At that time, the federal government is projected to pay 51.76 percent and state government 48.24 percent; an increase of more than 5 percent for the state.

Federal deficit reduction measures in Medicaid and in other social services and education programs will shift costs to states. For example, Targeted Case Management, a service reimbursable by Medicaid and used by states for children in foster care and other federally mandated programs, now has stricter definitions that limit states' ability to bill for this service thus increasing state expense. We can anticipate further federal deficit reduction measures at the expense of states, such as regulations that narrowly define rehabilitative services and those that define public entities as only those with taxing authority which limits sources of available matching funds for Medicaid. In addition, stricter audit guidelines and closer financial scrutiny are driving unofficial federal policy changes that also shift costs to the state.

Alaska is projected to have a significant increase in the elderly population. The Lewin Group and ECONorthwest's February 15, 2006 report "Long Term Forecast of Medicaid Enrollment and Spending in Alaska: 2005-2025" predicted substantial growth in spending on Alaska's Medicaid program, driven by a change from serving predominantly children to one dominated by seniors. The services needed by seniors, Home and Community-based Waiver Services, behavioral health, and personal care services, were identified as major cost drivers which will cause an increase to expenditures from the general fund.

The temporary increase in Medicare physician reimbursement for Alaska has lapsed, and the reduction in reimbursement has contributed to some physicians no longer accepting Medicare. Since Medicaid only pays after Medicare, health care access for those qualifying for both Medicaid and Medicare is impacted. In order to bring stability to this segment of the health care system, there needs to be a permanent federal adjustment made for Medicare reimbursement that reflects the significantly higher cost of providing health care in Alaska.

The Pacific Health Policy Group (PHPG) January 2007 report to Senate Finance offered several recommendations about Medicaid reform. The PHGP details inefficiencies in the Medicaid system that result in large general fund expenditures. It identifies approximately $220 million that is currently paid by Medicaid to non-tribal providers on behalf of American Indians and Alaska Natives. The PHGP report resulted in a $2.3 million Legislative appropriation for the Department of Health and Social Services to further define and implement the opportunities noted by the PHGP report on defining the future of Medicaid in Alaska.

Need for Accessible Information about Available Services

The boards and commission associated with The Trust report that Trust beneficiaries needing information about long-term care and other services often say they do not know where to turn. Seniors especially would like to speak to a "live" individual when they need information, rather than leaving phone messages and receiving a return call several days later suggesting additional numbers to call. The Aging and Disability Resource Centers (ADRCs) are moving toward becoming a "one-stop shop" for information about available programs, services, and benefits for seniors and people with disabilities. The ADRCs also plan to become part of Network of Care, a nationwide system to help consumers, their caregivers, and service providers locate specific services in their communities or regions via an interactive website and/or a toll-free phone number that is staffed around the clock.

ADRC's are a collaborative effort of the U.S. Administration on Aging and the Centers for Medicare and Medicaid Services offered in Alaska through five regional offices of the Statewide Independent Living Council or SILC (in Anchorage/Mat-Su, Fairbanks, Juneau, Kotzebue, and Kenai) as information resources to help streamline access to long-term care.

Specialized Senior Behavioral Health Services

Senior services providers report a growing number of clients experiencing serious behavioral health needs. Aggressive behavior and substance abuse are becoming more common and more problematic in settings such as senior centers and independent-living senior housing. Pioneer Homes and assisted living facilities are seeing more seriously mentally ill (though previously undiagnosed) individuals, and report that they are not prepared to serve these clients in a general population setting. When behavioral health issues overlap with ADRD, treatment is particularly difficult to locate. Isolation, depression and grief issues are also common among older Alaskans. Seniors often refuse to seek help from sources such as a community mental health center or a local Alcoholics Anonymous meeting for fear of stigma. Special approaches are necessary to identify, make contact with, assess, and provide behavioral health services to seniors. In many communities, no programs are in place to meet these unique needs.

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Attachment C

Alaska Health Care Strategies Council, "Final Report: Summary and Recommendations;" online at
http://www.hss.state.ak.us/commissioner/legislature/pdf/HCSPC_report.pdf

Alaska Health Care Strategies Planning Council

Final Report: Summary and Recommendations

Making Alaskans the healthiest people in the nation...

December 23, 2007

Table of Contents

Executive Summary

On February 15, 2007, Governor Sarah Palin issued Administrative Order #232 establishing the Alaska Health Care Strategies Planning Council in the Office of the Governor. The purpose of the Council was to build the foundation for developing a statewide plan to identify both short-term and long-term strategies that effectively address issues related to access, cost and quality of health care for Alaskans. Members of the Council, all appointed by Governor Palin, are listed in Appendix C.

The Council interpreted its charge from Governor Palin broadly, to focus on the overall goal of improving the health of Alaskans. Within that broad charge, the Council considered health care to be an important component in improving the health of Alaskans. According to the Council, health care is a broadly defined term, relating to the prevention, treatment and management of illness, preserving mental, behavioral, physical health, and dealing with chemical dependency.

In accordance with the order, the Council reviewed and synthesized the extensive body of existing research on the subject, agreed upon the most salient facts, and identified the most significant health care issues in the state. Based on seven overarching healthcare challenges identified by the Council, members articulated the following seven comprehensive health care policy goals:

- *Personal responsibility and prevention in health care will be top priorities for government, the private sector, tribal entities, communities, families, and individuals;*
- *Health care costs for all Alaskans will consistently be below the national average;*
- *Alaska will have a sustainable health care workforce;*
- *All Alaskan communities will have access to clean and safe water and wastewater systems;*
- *Quality health care will be accessible to all Alaskans to meet their health care needs;*
- *Develop and foster the statewide leadership necessary to support a comprehensive statewide health care policy;*
- *Increase the number of Alaskans covered by health insurance and encourage employers to offer a range of health insurance options.*

Because of its short time frame, the Council was unable to address the Administrative Order's directive to present fiscal information to accompany each of the short- and long-term strategies. Unfortunately, with only 24 hours of face-to-face meeting time, identifying the fiscal impact of recommendations remains unaddressed, and must be a top priority in future consideration by this or subsequent bodies.

The Council's Vision and Long-term Goal

At its inaugural meeting on June 11, 2007, Council members articulated an overall vision of health care in Alaska – that "***Alaskans are the healthiest people in the nation.***" This vision led to development of a concrete mission statement describing the ultimate

outcome of the Council's work: "***To develop strategies, including performance measures, to provide health care access to all Alaskans by 2014.***"

The "Fact-Based Process"
The work of the Council was facilitated through a "fact-based" process by Mr. Dennis McMillian, President and CEO of The Foraker Group, an Alaskan-based nonprofit corporation. Members were asked to review existing research and initiatives, and hear from subject-matter experts on the major issues in Alaska's health care system. Only those facts garnered from existing sources and/or presented to the Council at its meetings, and which were widely recognized by Council member as salient to the process, were allowed to remain in the conversation.

While time-consuming, the fact-based process allowed the development of a solid basis for discussing the issue of health care in Alaska, highlighting the major challenges with that system, and identifying realistic solutions to address those challenges.

Alaska's Health Care Challenges: A Strategic Plan for the Future
In the opinion of the Council, there are seven challenges requiring immediate and comprehensive attention in Alaska's health care system:

- *Prevention and personal responsibility don't play big enough roles in the health and health care of Alaskans;*
- *Receiving quality health care in Alaska is expensive, well above the national average, and increasing;*
- *There are significant shortages in the health care workforce across the state;*
- *Water and wastewater systems in many rural communities lead to health problems;*
- *Quality health care is difficult to access for many Alaskans, urban and rural;*
- *There must be consistent and focused state and local leadership to improve the health of Alaskans, and build a comprehensive health care system in Alaska;*
- *Health insurance is an important if as yet misunderstood part of comprehensive health and health care.*

Based on the vision of a healthy Alaska, a one-page "Alaska Health Care Action Plan" was developed by the Council. The plan appears in the following section, and includes a combination of long-term and short-term goals. Where applicable, the short-term strategies appear at the beginning of the relevant goals.

During its work the Council was able to generate dozens of possible solutions to address the challenges, much of that the result of "brain-storming." The identified solutions are presented in Appendix A. Most require development of implementation plans, which was considered beyond the scope of the Council's work, especially given the short window for completion of its tasks. Although they are not developed fully, the articulated solutions in the plan, and within Appendix A, present a real and actionable foundation for helping to meet the goals in the "Alaska Health Care Action Plan."

Alaska's Health Care Action Plan: "*Making Alaskans the healthiest people in the nation.*"
Long-Term Goals and Strategic Directions (2008 – 2014)

Goal One: Health costs for all Alaskans will consistently be below the national average.

- Increase the place of consumerism in health care purchasing by giving people control over their health care dollar – the foundations are accessible, transparent, evidence based price/quality information about providers and services (short-term)
- Create an easily accessible and constantly updated website containing evidence-based price and quality information about health care providers and services (short-term)
- Increase community-based health care services, both public and private sector
- Stabilize the costs of health care by reducing the rate of increase relative to other states (national increase is 6%, decrease Alaskan rate to 4% annual increase)

Goal Two: Alaska will have a sustainable health care workforce.

- Increase WWAMI seats to 50 per year, and increase seats in UA Nursing and Nurse Practitioner programs (short-term)
- Develop policies and systems to alleviate the health care worker shortage, and prevent it from recurring
- Implement a doctoral-level nursing program at the University of Alaska to meet the 2015 deadline for Nurse Practitioner education requirements

Goal Three: All Alaskan communities will have clean and safe water and wastewater systems.

- Improve adherence to the state's existing water and wastewater treatment "plan," through the Village Safe Water Program

Goal Four: Quality health care will be accessible to all Alaskans to meet their health care needs.

- Expand tele-health and electronic health record systems, taking the lead in pursuing matching FCC grant funds (short-term)
- Increase presence of the public health system, particularly public health nurses, especially in rural communities (short-term)
- Increase access of Alaskans to a primary care provider and behavioral health provider when they are needed
- Decrease the likelihood that Alaskans will use emergency rooms for primary care
- Reduce the impact of existing barriers to health care accessibility by exploring private enterprise incentives
- Improve primary and long-term health care options for elders, particularly with regard to Medicaid and Medicare

Goal Five: Personal responsibility and prevention in health care will be top priorities for government, the private sector, tribal entities, communities, families, and individuals.

- Decrease the impact of obesity, smoking, substance abuse and other lifestyle factors on the health of Alaskans, through intense public education with public and private partners (short-term)
- Improve the likelihood that every Alaskan will choose to live a healthy lifestyle and make healthy lifestyle choices
- Increase the place of personal responsibility in health care decision making for all Alaskans

Goal Six: Develop and foster the statewide leadership necessary to develop and support a comprehensive statewide health and health care policy.

- Create an ongoing, quasi-independent, non-partisan, volunteer "Alaska Health Care Commission" in statute (short-term)
- Elevate the discussion of health care to a statewide audience

Goal Seven: Increase the number of Alaskans covered by health insurance

- Raise the eligibility criteria for Denali KidCare from the current 175% to 200% of federal poverty limits (short-term)
- Reduce potential for financial impact from catastrophic loss by supporting new and innovative approaches to insurance for individuals, which would be consumer-owned, portable, and purchased with pre-tax dollars
- All Alaskans have at least a catastrophic, incentive-based insurance option (i.e., high deductible coverage)
- Encourage employers, through varied incentives, to offer a range of insurance options/choices to employees – to include at a minimum, high deductible plans

Alaska's Health Care Challenges: Discussion and Recommendations
The Council engaged in lengthy discussion of the seven main challenges facing Alaska's health care system, and generated the following discussion points related to each.

- *Defining the specific problem or problems*
- *Why addressing them through comprehensive state action is important*
- *What should be done about it – in other words, identifying desired outcomes*

In addition to discussing what should be done to address each problem, the Council generated possible solutions and solicited public comment on the Health Care Action Plan. A Strategic Implementation Table (Appendix A) list the many solutions generated by the Council, and sets the foundation for implementation of selected short and long-term strategies. The full text of public comment will be presented to Governor Palin under separate cover, but the overriding themes contained within those comments are summarized in Appendix B.

Goal One: The High Cost of Health Care in Alaska

What's the problem? *The costs of producing quality health care are high, and therefore it is quite expensive to be a consumer of that care. The costs of health care in Alaska are already well above the national average, and like the rest of the nation, are increasing.*

Why this is important: *A new approach to this problem must be embraced if there is to be long-term, positive reform in Alaska's health care system. If Alaska continues along the same path, the results will remain unchanged. Reducing the rate of increase in the costs of health care is a "must do" priority, and Alaskans need to get the best value for health care dollars spent. Every health care dollar must be spent wisely. Broadly stated, the high cost of health care is a barrier to many Alaskans getting the health care they need. The present system supports the high and increasing costs of health care and inefficient utilization of health care dollars.*

What should be done about it: *Decreasing the rate of growth in health care costs in Alaska will require development of a high-quality health care system that is evidence-based, consumer driven and market-responsive. With respect to lowering costs, insurance that is portable and consumer-owned plays a central role, and requires much more discussion at the state level. Overall, giving people more control over their health care dollar is a central component, as is providing appropriate, accessible, transparent, and evidence-based cost and quality information about health care providers and services. In the short-term, one of the most important goals should be state creation of an easily accessible and up-to-date website providing health care cost and quality information to Alaskans. These strategies alone are not sufficient to reduce the overall cost of health care in Alaska, nor to reduce the rate of growth. Closely related are the subjects of personal responsibility, access to health care, increasing the number of health care providers, and insurance.*

Goal Two: The Health Care Workforce

What's the problem? *There are significant shortages in the health care workforce across the state. Alaska needs more health care workers throughout the system, at all levels.*

Why this is important: *Without ample health care workers, the system will continue to falter – it is already showing signs of strain. Lack of a sustainable health care workforce is a primary factor in the increasing costs of health care, and also in the decreasing access of health care for Alaskans. In addition, significant access issues exist in both urban and rural areas, which will likely require expansion of the health care workforce.*

What should be done: *Statewide policy should enable the creation of a sustainable health care workforce that alleviates the current shortage and prevents it from recurring. A good start is to "grow more of our own" within Alaska, by presenting health care professions more prominently as viable career options, with students continually encouraged to build the skills and the interests necessary to pursue health care careers. In the short-term, to increase primary care providers in the state, the number of WWAMI seats should be increased to meet the projected need of 50 per year in the next decade. In concert with that, the University of Alaska nursing doctorate degree should be implemented as well. The number of resident positions in the Family Practice Residency Program should be increased, as should the number of graduates in both the UA Nursing and Nurse Practitioner Programs.*

Goal Three: Sustainable Rural Water and Wastewater Systems

What's the problem: *Water and wastewater systems in many rural communities are inadequate, unsafe, or non-existent, and can be a major cause of health problems within those communities.*

Why this is important: *There is a strong correlation between the health of Alaska's rural residents, and water and wastewater safety. Building and operating clean drinking water and wastewater disposal systems is one of the most effective means for improving the health and wellness of rural Alaskans and rural communities.*

What should be done: *There is an active state program in place to bring sustainable and safe drinking water and wastewater disposal systems to all of Alaska's rural communities – the Village Safe Water Program. However, the real success of that program depends on the recognition by state policy makers that there is no "one" size fits all" approach to bringing those systems to rural Alaska. What works in one community may not work in another. Efforts to provide infrastructure that the community can support in the future should continue. The state's long-term health care policy, therefore, should improve and ensure the state's adherence to the "plan" for bringing sustainable and appropriate safe water and wastewater systems to every Alaskan community.*

Goal Four: Access to Health Care

What's the problem? *Accessing quality health care is difficult for many Alaskans, both urban and rural. There is little consistency of access to health care for all Alaskans – some have it all the time, some have it some times, and some have it hardly at all. In Alaska's urban areas there is a lack of access to necessary specialized care and efficient "same-day" primary care. In rural communities, there is often no access at all to health care because of a variety of barriers, including costs, geography, transportation challenges, lack of providers and much more.*

Why this is important? *The lack of access to quality health care contributes to Alaskans' wellness challenges. Being able to guarantee timely access to primary care, in particular, presents significant challenges; but appropriate primary care is one of the most effective means for keeping Alaskans healthy. There was considerable discussion among members about the positive impact of Community Health Centers, and the state's public health nurses, in providing greater access to health and health care opportunities*

There was agreement among Council members on two major points relevant to health care access. First, Community Health Centers (CHCs) are a valuable part of the "health care safety net" for Alaskans. Second, the state's public health nursing structure is one of the most important mechanisms for affording greater access to a wider range of health care. The problem with CHCs and public health nursing is that both programs are under-funded. Community Health Centers are federally funded, and most states provide supplemental financial assistance because CHCs are viewed as an important part of the overall health care system in those states. Partly due to the provision of health care services to the under-insured and uninsured, CHCs consistently face budgetary challenges. In Alaska CHCs receive virtually no funding from the state. Similarly, the state's public health nursing system has been chronically under-funded for years. Ever-decreasing state dollars for the Public Health Division has meant that fewer and fewer public health nurses are able to do their important work improving the health of Alaskans.

What should be done: *Accessing health care should not be difficult for Alaskans, and broad policies that improve access to primary care and behavioral health care should be the focus of any state health care policy. Strategies should include: 1) the state becoming more actively engaged as an active investor in the Community Health Center system through supplemental funding and regulatory relief; 2) appropriate funding for and utilization of the state's Public Health Division, in particular the Public Health Nursing program, 3) building monetary and other incentives into the health care system which encourage Alaskans to more effectively utilize primary care opportunities; 4) leveraging information technologies such as tele-health and electronic health record systems which can improve access while reducing costs; and 5) reducing barriers to private clinicians practicing in underserved areas. In the very short term, the state could take the lead in guaranteeing that the required "match" associated with the current $10 million Federal Communications Commission tele-health grant is made.*

Goal Five: Prevention and Personal Responsibility

What's the problem: *Prevention and personal responsibility play too small a role in health care, including maintaining and improving health. While Alaskans may understand the connection between their lifestyle choices and their individual health, for the most part they do not make a connection between personal choices, having a personal stake in their health, and the cost of their health care. Alaskans are not optimally encouraged and equipped to make the kinds of choices that improve health and subsequently decrease health care costs.*

Why this is important: *More healthy Alaskans translates into fewer sick Alaskans, and improved quality of life with resultant cost savings. A clear understanding of the role of personal choice in individual health status and the impact on health care costs, as well as the central role of government in supporting health choices, are critical components in developing long-term strategic health and health care policies.*

What should be done about it: *Solving this problem requires a two-pronged approach. First, Alaskans must be encouraged to play a much greater role in their own wellness by having both a personal and financial "stake" in their own health. Having a "stake" in their own health is the product of a personal investment in wellness, and realizing the financial benefits of saved dollars by maintaining healthy lifestyles. In the opinion of the Council, the most effective mechanism for increasing the personal health investment of Alaskans is incentivizing and supporting positive change.*

Second, governments, school districts, tribal entities and other employers are uniquely situated to be catalysts for positive change. These entities have the influence to help Alaskans understand and make healthy choices, while at the same time avoiding those lifestyle decisions that contribute to poor health.

Goal Six: Statewide Leadership

What's the problem: *A lack of consistent statewide leadership makes development of comprehensive statewide health and health care policy challenging.*

Why this is important: *Public leaders have a pivotal role as catalysts for positive change. Commitment at the executive and legislative levels to comprehensive and lasting change will effect health and health care in Alaska.*

What should be done about it: *The Council believes that government has an obligation to "jump start" healthy choices through incentives, and in addition build the necessary incentive structures for the future. Positive change will be the result of a concerted effort by the governor and the legislature, through partnering with local communities, in a long-term commitment to maintain positive momentum. The key is elevating the discussion of health and health care to the statewide level.*

One of the most effective mechanisms for solidifying that long-term commitment to bringing positive change to Alaska's health care system is to establish through statute a quasi-independent "Alaska Health Care Commission," which would seek to provide advice on innovative solutions, and act as a catalyst for positive change. The Commission would be responsible for advising state leaders on incentivizing positive lifestyle choices; fostering ongoing research; controlling health care costs; improving access, and ensuring a sustainable health care workforce.

Goal Seven: Health Insurance

What's the problem: *Over 100,000 Alaskans – including more than 14,000 children – are without health insurance at some time during any given year. When insurance is made available, there is often a misconception that it should cover everything, from routine and predictable events to catastrophic occurrences and long-term care; this misconception increases the cost of health insurance beyond the reach of many Alaskans.*

Why this is important: *Having access to health insurance coverage is one of the most significant determinants of access to appropriate health care. Alaskans who do not have health insurance are often unable to get the services they need to become healthy, and to maintain wellness.*

When uninsured Alaskans do seek health and health care services, it is often for expensive chronic conditions which could possibly have been avoided if they had had health insurance coverage, or access to appropriate primary care. When Alaskans who may not be eligible for Medicaid and Denali KidCare do access health care, they are often unable to pay and often seek care in a hospital emergency room, which is the most expensive and inefficient mechanism for receiving primary care. The costs of such access are borne across the whole health care system, which raises the overall costs of health care in Alaska. When the uninsured who are not eligible for Medicaid and Denali KidCare do pay for health and health care services, they often do so at significant personal and family financial impact.

Not having insurance is only part of the problem, and simply providing insurance under the current structure is not the answer. With the exception of preventative health services, comprehensive health insurance is not an efficient way to pay for routine and predictable care, such as the common cold, ear infections, hang nails, and sprained ankles. Whereas health insurance IS the most important tool for protecting people from unplanned catastrophic health events, it is an inefficient way to pay for routine expenditures. Therefore, the current system, which relies on insurance to pay for routine and predictable health care expenses, raises the costs of premiums above the reach of many Alaskans.

What should be done about it: *More Alaskans need to be covered by efficient health insurance plans. Increasing the number of Alaskans covered by efficient health insurance will be the result of several specific actions. In the short-term, the Council recommends that the state immediately pursue and support change in the Denali KidCare program to make Alaskan children in families at 200% of the federal poverty level eligible for coverage. While there was a majority vote among Council members regarding this expansion of Denali KidCare coverage, the role of that program within an efficient and effective system of health care coverage is worthy of continued debate at the statewide level, through the recommended "Alaska Health Care Commission."*

To most effectively cover the adults and remaining children without health insurance, bringing consumerism to the forefront of Alaska's health insurance structure is important. Alaskans should have access to choices, through a wide range of health insurance options, including at the very least high deductible coverage with a strong prevention component. The key to success is insurance that at least covers catastrophic care, so no Alaskan suffers from the extreme financial burden of catastrophic or unanticipated health events. Whereas some uninsured Alaskans are not working, most are working for employers who would like to, but cannot necessarily afford to, provide health insurance coverage for their employees. Therefore, through incentives, Alaskan employers should be encouraged to offer a wide range of coverage choices, to include at a minimum, high deductible coverage

Consumerism is an essential component of bringing rationality to the health insurance structure in Alaska, and extending coverage to as many Alaskans as possible. The key to success is insurance that at least covers catastrophic care, so no Alaskan suffers from the extreme financial burden of catastrophic or unanticipated health events. In addition, insurance must be consumer-owned, market-responsive and portable; this recommendation has received attention elsewhere in this report. Coverage options debated in the Council's discussions, which are by no means exhaustive, include Health Savings Accounts, Health Opportunity Accounts, and high-deductible plans with a strong prevention component. This list provides a solid foundation from which to continue the ongoing discussion about expanding health care coverage for all Alaskans.

Summary and Conclusions

Resolving the health and health care issues in Alaska will not be the result of a single solution. Instead, bringing real and lasting change means working together in partnership. Many of the solutions presented within this report fall squarely within the purview of state government. But no matter how committed state government is, solutions will not be forthcoming without involving all stakeholders as partners for change – from individual Alaskans to families, nonprofit organizations and private sector employers and employees, communities and local governments, tribal entities, state government, the governor, the legislature, and the federal government.

The Council has deliberately not prioritized solutions for solving the problems it has identified with the health and health care system in Alaska. Indeed, all of the problems must be addressed concurrently if real, long-term change is to take place. Having said that, within those identified by the Council, one is definitely the larger-order problem, meaning if we can solve it, many of the other problems will be alleviated. That problem is the lack of prevention and personal responsibility.

By improving the place of prevention and personal responsibility in the health and health care decision-making rubric of Alaskans, costs of health care could be lower than they otherwise would be. With concentration on a wellness model of health care, as well as state support for the Community Health Center system and a robust public nursing program, the current access problems could be significantly reduced. Most Alaskans will have both the motivation and the means to maintain their own wellness. And with greater wellness, the composition of the health care workforce will likely change, decreasing the dependence on health care professionals who are the most difficult and most expensive to attract and retain.

Becoming the healthiest people in the nation is indeed a grand vision – but it is real and achievable.

Respectfully Submitted,

The Alaska Health Care Strategies Planning Council
December 23, 2007

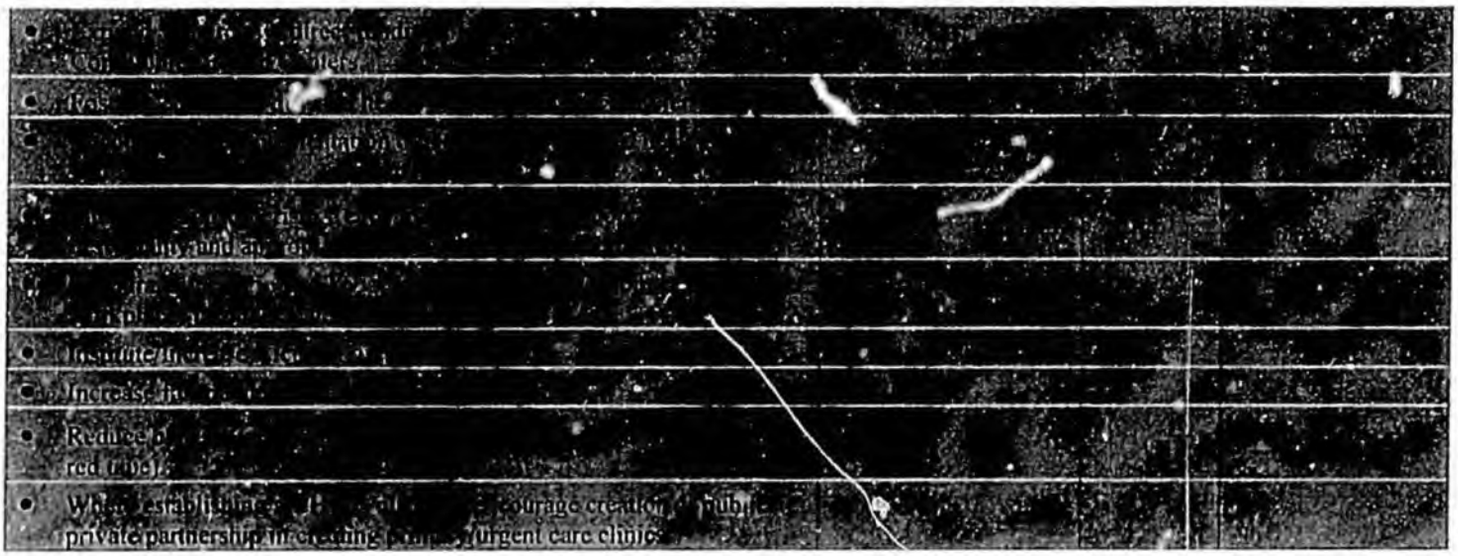
Appendix A: Strategy Implementation Table

2008 / 2009 / 2010 / 2011 / 2012 / 2013 / 2014

Short-Term Strategies *(for implementation between 2008 and 2010)*	Action Required (Policy, Regulation, Statute)	Expense	Implementation Timeline

• Pay the tuition – or forgive student loans – for residents from rural Alaska who are willing to practice – after graduation – in their home community.			
• Institute student loan forgiveness for medical/health professionals and para-professionals who make a commitment to stay in Alaska.			
• Provide grants for low-income vocational/tech students in Certified Nurses Assistant/Pharmacy Tech programs.			
• Increase the presence of public health system, particularly public health nurses, especially in rural communities.			
• Follow through on existing state plans for safe drinking water and wastewater, through the Village Safe Water Program and other efforts.			
• Support and expand telemedicine and tele-behavioral medicine – include education, maintenance and equipment upgrades.			
• Increase behavioral health training and support.			
• Increase available slots in Physician Assistant and Nurse Practitioner programs at the University of Alaska and with other academic partners.			
• Increase number of Residents in Family Practice Residency Program.			
• Create a greater awareness of the distinction between routine and predictable health care costs (less expensive) and unanticipated or catastrophic costs (more expensive).			
• Promote Health Savings Accounts and high deductible insurance plans – for individuals and employers.			
• Provide incentives for providers and consumers, with performance measures and rewards (for providers), based on evidence-based results.			
• Foster better informed consumers through creation of a dynamic (continuously updated) website providing transparent quality and cost information about medical services, prescriptions, etc.			
• Build teaching capacity in K-12 schools to excite young Alaskans about the physical sciences generally, and the health care field in particular.			
• Increase penalties for selling alcohol to youth.			

Long-Term Strategies ***(for implementation between 2010 - 2014)***	**Action Required** (Policy, Regulation, Statute)	**Expense**	**Implementation Timeline**
• Support information technology improvements.			
• Promote insurance that is portable, consumer-focused and consumer owned, purchased with pre-tax dollars.			
• Increase Alaska WWAMI seats to 50 /year – the projected need to meet demand in the next 10 years.			
• Institute doctoral NP program at UAA.			
• Increase the availability of education programs for health care disciplines.			


Reduce
red tape
private partnership in creating
urgent care clinics

Appendix B: Summary of Public Comment Received by the Council

- Support the Community Health Centers as a way to improve access and decrease use of the emergency room for primary care.
- Improve e-health
- Increase workforce, specifically mid-level practitioners
- Incorporate incentives to attract and retain necessary health care workers, including loan forgiveness and other repayment incentives
- Make sure to get the mix right of what is needed in the health care workforce
- Recruitment programs are best done in state
- Build interest in the health care field at the middle and high school level
- Develop a statewide group with oversight responsibility for recruitment and retention – because it cost too much for individual organizations to do it
- Eliminate shortage of UA educators in health care professions
- Put fluoride in rural water systems
- Improve the place of preventative dental service in the health care continuum
- Prevention, collaboration and partnerships are the key to improving access
- Building existing programs makes the most sense, versus making new programs and the associated structures
- Remove bureaucratic barriers to effective health care access
- Examine innovative solutions that involve Medicaid reimbursement
- Acknowledge and build upon the work of public health nurses and the public health nursing program
- Include alternative treatments when talking about prevention and personal responsibility
- Improve worksite health as a cost-saver
- Most feel there should be basic, portable insurance coverage for all Alaskans
- Concentrate on preventing sickness rather than curing it
- Should be at least some mechanism to insure a minimum coverage for all Alaskans
- People with disabilities have real trouble finding primary care – the state should close the gap in those services
- Alaskans need a range of services that are affordable – maybe the state should subsidize those services
    - Don't forget the severely disadvantaged – Alaska's working poor
- Funding for substance abuse and mental health are effective preventative services, which lead to increase wellness
- State must support the e-health FCC grant
- State should not be shy about supplementing the loss of federal Medicaid dollars with state support
- Behavioral health in Alaska has taken huge cuts, and the system is on the verge of crisis
- The broadly stated goals of the Council really skip over the importance of behavioral health and substance abuse as preventative factors

- Oral health needs to play a more significant role in overall health
- Need more dental techs in the health care workforce
- Realize that turning 65 in Alaska means no more health care for most elders
- Make it easy for people to navigate the health care system – now it is really difficult
- Remove barriers that prevent Alaskans from receiving necessary primary care, and to get Denali KidCare after birth
- There MUST be a continued forum for addressing health care issues in the long term

Appendix C: Alaska Health Policy Council Members

The council is composed of 14 Alaskans appointed by the governor:

- Jeff Davis of Anchorage has served as president of Premera Blue Cross Blue Shield of Alaska for nine years, which provides insurance for 180,000 Alaskans statewide.
- Cathy Giessel of Anchorage is a registered nurse and advanced nurse practitioner whose career and experience spans more than 30 years.
- Dr. Derek Hagen of Anchorage is a doctor of osteopathy associated with Primary Care Associates, the largest private family practice in the state.
- Thomas Hendrix, PhD, of Anchorage is an assistant professor at the University of Alaska School of Nursing specializing in the policy, economics, assessment, and fundamentals of health care.
- Don Kashevaroff of Anchorage is the chair and president of the Alaska Native Tribal Health Consortium, and serves as the primary spokesman for the Consortium regarding state and federal funding, legislation, and regulatory issues.
- Brian Slocum of Fairbanks is the administrator at Tanana Valley Clinic, the largest multi-specialty, multi-site practice in Alaska.
- Dr. Michael Carroll of Fairbanks is a private practice physician, specializing in internal medicine and oncology.
- Donna Fenske of Homer served the State of Alaska as a public health nurse from 1979 to 2004 and most recently has provided community health aide services in Port Graham and Nanwalek clinics, and nursing services to K-12 students in rural communities in the Kenai Peninsula Borough School District.
- Steve Horn of Soldotna is the executive director of the Alaska Behavioral Health Association whose members are the businesses that provide direct services to recipients of behavioral health services throughout the state.
- Dr. Cathy Baldwin-Johnson of Wasilla is a private practice family physician and the 2002 National Family Physician of the Year from the American Academy of Family Physicians.
- Karen Rhoades of Wasilla is the owner and operator of Northern Living Centers, a five bed assisted-living home.
- Tim Joyce of Cordova is a three-term mayor of the City of Cordova who has dealt with escalating community medical costs, a constant turnover of medical center administrators and a community medical center that is continually in need of city assistance.
- Rod Betit of Juneau is the president and CEO of the Alaska State Hospital and Nursing Home Association (ASHNA), a not-for-profit association with members representing hospitals, nursing homes, and Native Alaska health care providers.
- Dr. Bob Urata of Juneau has served as a family physician for over 23 years, and has served on the Bartlett Regional Hospital Board of Directors.
- Commissioner Karleen Jackson managed the Health Council. Serving as ex-officio, non-voting members were Senator Bettye Davis and Representative Peggy Wilson, chairs of the Health, Education and Social Services committees in the Alaska State Legislature.

Attachment D

Turning Point, "Transforming Public Health State by State" and "States of Change: Stories of Transformation in Public Health;" available online at *http://www.turningpointprogram.org/Pages/archives.html*

Turning Point

Collaborating for a New Century in Public Health

Transforming Public Health State by State

Produced by the Turning Point National Program Office at the University of Washington.

Acknowledgments

The Turning Point National Program Office gratefully acknowledges the enthusiasm of the Turning Point state partnerships in the creation of these fact sheets and the accomplishments they describe. Expertise provided by staff from Radiant Communications and the RWJF's CONNECT project was also invaluable in supporting the development of these fact sheets.

Funding from The Robert Wood Johnson Foundation supports the efforts of the Turning Point National Program Office and the state partnerships.

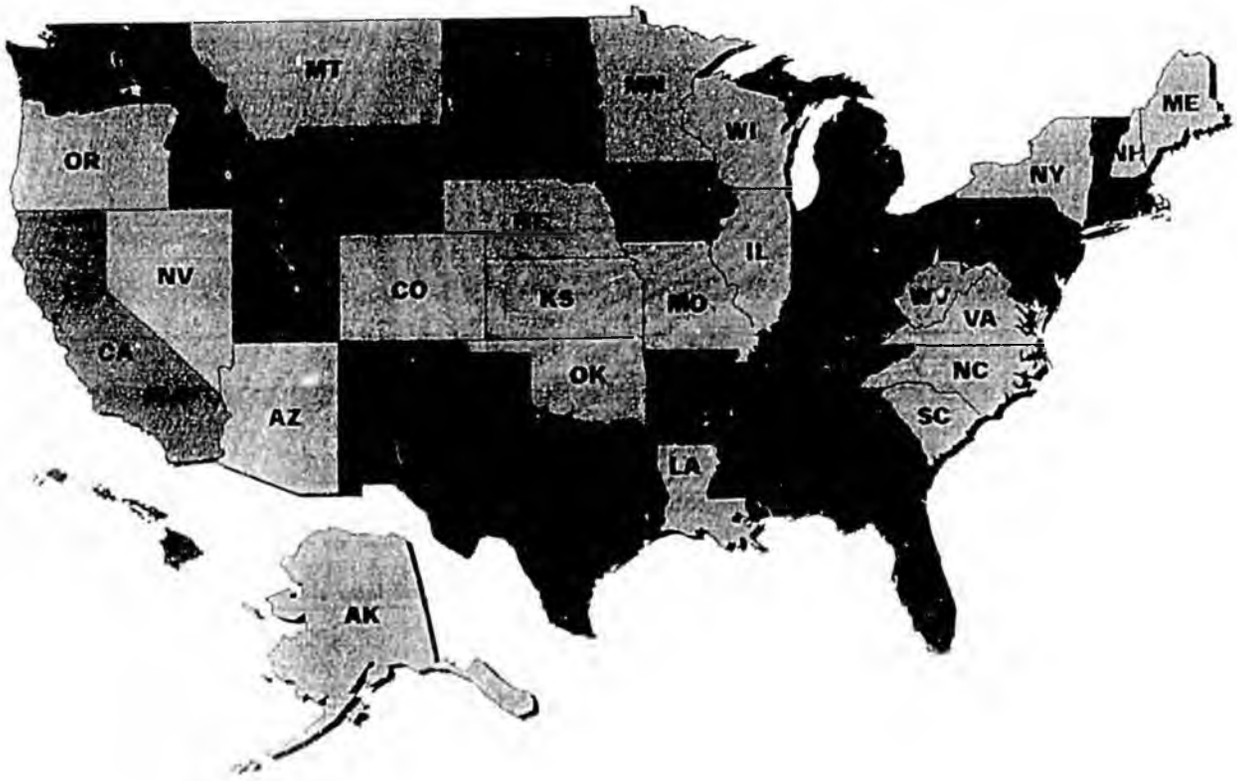
At no time in recent history has the system that supports and protects the health of the American public been as much on the minds of our national policy makers as it is today. Potential and existing public health threats from bioterrorism and emerging infectious diseases have made the public and our national leaders more aware of the role of public health workers, their partners, and their supporting institutions. Public health systems have always functioned to keep populations healthy and to recognize and respond to health threats, but a uniqe opportunity exists today to communicate more effectively how this is done and what is needed to maximize these systems and invest in those who do this work.

The pages that follow represent the extraordinary accomplishments of those who have made significant improvements in the public health systems in their states and communities through the Turning Point Initiative. With support from The Robert Wood Johnson Foundation, state wide partnerships with representatives from local communities, businesses, hospital corporations, nonprofit groups, minority coalitions, religious organizations, and many others have been working together to create more efficient and effective systems for improving the public's health. This work has recognized and nurtured the interest and investment of multiple sectors in wanting to create a healthy environment for all. The states and communities involved in the Turning Point process have sparked public health innovations by identifying strengths and weaknesses in their public health systems; understanding the scientific, political, and social environments that affect public health systems and the health of their populations; and valuing the participation and contributions of other sectors in establishing new approaches to improving health.

It is with pride that public health partnerships from Turning Point states and the Turning Point National Program Office present these successes in this publication. These fact sheets highlight to national policy makers, what can be and has been achieved through planning, partnerships, and concerted efforts at improving systems for effective health promotion and protection. These fact sheets also outline what Turning Point partnerships and the National Program Office can offer to national policy makers who want to be more responsive to the health needs and public health safety of their constituents.

Bobbie Berkowitz, PhD, RN, Director
Turning Point National Program Office
Seattle, Washington
May 1, 2003

Turning Point State Partners Across the Country



Contents

Turning Point

Collaborating for a New Century in Public Health

A strong public health system is crucial for protecting and improving the health of Americans.

Make Every Health Dollar Count

Half of the world's health care dollars are spent in the U.S. But in 2000, the U.S. ranked 26th among all nations in terms of our life expectancy. At the same time, only 1% of federal health dollars are spent on public health efforts that would improve our overall health.

Strengthen Public Health Systems

Now, more than ever, our country needs a vigorous public health response to threats such as bio-terrorism and the growing public health concerns of obesity, violence, and tobacco-related illnesses.

These health concerns cause more than 2 million avoidable deaths in the U.S. every year.

Budget cuts at all government levels have devastated the public health workforce and capacity to respond at the very time that emerging threats to the public's health regire advances in public health science, training, and leadership.

Public health needs sustained support for improving the nation's health and preparedness.

For more information

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THE ROBERT WOOD JOHNSON FOUNDATION

What is Turning Point?

Individuals and organizations from different sectors in many communities and states have come together to create a public health system that works smarter and better. Transforming public health so that it achieves the goals of preventing disease and injury, protecting the public from threats to health, and promoting healthy behaviors are efforts at the heart of Turning Point.

At the national level, Turning Point collaborates with other public health organizations to help realize the Institute of Medicine's vision of a strong and effective public health system.

How is Turning Point improving public health?

Turning Point has developed specific models for a more effective and responsive public health system. Through 21 state partnerships of state and local public health and community-based agencies and through five national collaboratives we are:

- Improving the accountability of public health efforts
- Developing a model law to update public health statutes
- Increasing the effectiveness of public health information technology
- Motivating changes in behaviors to promote good health outcomes
- Promoting skills and competencies of public health practitioners and leaders

What can Turning Point help you do?

- Identify the most important health needs of residents in states and communities nationwide
- Create effective and accountable structures to deliver public health services to states and communities
- Develop population data that supports decision-making about public health priorities
- Generate strategies to improve the health status of individuals, families, and communities
- Target the best ways of eliminating health disparities among and within populations
- Provide evidence of effective partnerships that have transformed public health systems

Support

The Turning Point Initiative is funded by The Robert Wood Johnson Foundation. The National Program Office is located at the University of Washington School of Public Health and Community Medicine.

Alaska Turning Point

Collaborating for a New Century in Public Health

A strong public health system is crucial for protecting and improving the health of Americans.

Alaska's Public Health

The effectiveness of Alaska's public health system is challenged by the emergence of new public health problems and environmental issues and by changes to health systems, health care financing and government structures.

Public health has a mission to protect and improve health. To carry out this mission effectively and use its resources wisely, the public health system needs up-to-date information about the diseases, conditions, and other health threats affecting population groups. Among the most significant and persistent public health concerns in Alaska today are tobacco use, alcohol consumption, injuries, suicide, nutrition, and chronic diseases.

Inadequate access to health status statistics and information was identified in the Alaska Public Health Improvement Process as a significant problem in Alaska's public health system. Addressing this deficiency is essential for making progress toward Alaska's health improvement priorities.

Alaska needs a public health information system accessible to all components of our diverse public health system to assist with decision making at all levels.

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What is Alaska Turning Point?

The national Turning Point Initiative aims to transform and strengthen the public health system in the United States by making it more community based and collaborative. In Alaska, Turning Point is developing a public health information system. The goals of this project are to:

- Provide information to policy makers, public health system partners, and the general public about the health status of Alaskans.
- Provide community-based organizations with the data and information they need, as well as the technical assistance on how to use it, in order to conduct community assessments and plan health improvement initiatives.

How is Turning Point in Alaska improving public health?

- Providing direct access to policy makers, health professionals, and community members needing useful information for their own planning and decision making. Resources developed by Turning Point and now available on the Internet can be used to assess health needs and establish priorities on a state, regional, or local level.
- Establishing a permanent and ongoing capacity for data compilation, analysis, and dissemination of public health information. This capacity is important for:
  - Recognizing trends and monitoring health improvement.
  - Informing policy making, program management, and program evaluation with current, comprehensive information.
  - Identifying and setting goals to be reached among communities throughout Alaska using data to impact key health issues.
- Convening Alaskans from rural and urban communities, Native organizations, state and federal agencies, and private businesses to contribute their knowledge and expertise to public health decision making and to setting health goals. Two publications resulting from one such partnership describe the current health status of Alaskans, set targets for health improvement, and describe strategies that have been used in Alaskan communities to address public health problems.

What can Alaska Turning Point help you do?

- Identify specific health issues and barriers to community health in Alaska
- Access data and information for making decisions regarding allocation of resources and the structuring of systems
- Monitor and protect the health status of Alaska residents

Support

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Healthy Alaskans 2010 Healthy Communities

Arizona Turning Point

Collaborating for a New Century in Public Health

A strong public health system is crucial for protecting and improving the health of Americans.

Arizona's Public Health

Arizona's population has almost doubled in the last 20 years; but the public health workforce has not kept pace. Arizona has only 48 public health workers for every 100,000 residents, nationally the rate is 158 per 100,000. Only 2.3% of health care expenditures in Arizona are spent on public health.

Arizonans' life expectancy is 71 years (55 for Arizona Native Americans), compared to the national average of 76 years. The leading causes of death in Arizona are largely preventable through access to care, education, and changes in behavior.

An estimated 18.4% of Arizonans lack health insurance, compared to 14.5% nationally.

An Arizona public health success story is that fewer Arizonans use tobacco than the national average (18.6% compared to 23.2% nationally). Disease prevention and health promotion programs can improve the public's health, but they happen through broad planning, public involvement, and a strong public health system.

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What is the Arizona Turning Point Project?

The national Turning Point Initiative aims to transform and strengthen the public health system in the United States by making it more community based and collaborative. Turning Point in Arizona works collaboratively with communities and key partners to improve the public's health and promote sound public health policies. The project addresses public health workforce development needs, information dissemination, disparities in health status, and public health advocacy and seeks to make the public health system in Arizona more effective and responsive to community concerns and issues.

How is the Arizona Turning Point Project improving public health?

- Providing workforce development for frontline public health workers through training and technical assistance in an "Academy Without Walls" to strengthen the public health workforce
- Increasing direct access to public health information through the creation of Public Health Information Centers in public libraries, local health departments, and tribal service centers, providing access to public health information and building working relationships between libraries and local health departments
- Assessing local county and tribal public health workforce competencies in partnership with the Arizona Local Health Officers' Association by implementing *The Public Health Competency Handbook,* an assessment and evaluation tool for local health departments to improve public health competency of individuals and organizations
- Providing skill building and knowledge to local communities about how to advocate for their own health needs and encourage community participation in statewide public health planning

What can Arizona Turning Point help you do?

- Address public health policies and priorities identified by a planning group of more than 100 individuals representing state and local community partners
- Access opportunities to engage in community dialogue about promoting, protecting, and preserving the public's health
- Provide up-to-date information about emerging public health issues and link individuals, communities, and organizations to public health experts

Support

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California Turning Point

Collaborating for a New Century in Public Health

A strong public health system is crucial for protecting and improving the health of Americans.

California's Public Health

With 61 public health departments in 58 California counties and 3 municipalities, California has one of the best public health systems in the nation. Yet, existing structures are not adequate for the types of resources needed to improve health.

The complex issues related to lifestyle, environment, and emerging infectious diseases require comprehensive solutions and a public health system prepared to address the range of factors that most influence community health.

The leading causes of death for Californians are preventable health problems caused by tobacco use, poor diet and lack of exercise, alcohol, infectious agents, and pollutants. Obesity alone currently costs California $3.12 billion a year in direct medical costs and lost productivity.

Today's public health system must be based on strong health departments working collaboratively with communities to confront the changing social and environmental sources of preventable illnesses.

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What is Turning Point in California?

The national Turning Point Initiative aims to transform and strengthen the public health system in the United States by making it more community based and collaborative. In California, Turning Point has a formal linkage with the Partnership for the Public's Health, a statewide initiative funded by The California Endowment and administered by the Public Health Institute. The Partnership for the Public's Health is a five-year initiative that supports collaborative planning for community health improvement among 14 public health departments and 37 community collaborative groups in California.

How is the Partnership for the Public's Health improving health?

- Supporting the development of effective and responsive public health systems
- Mobilizing and developing effective public health leadership in communities through partnerships between local health departments and community organizations to support sustainable community health improvement initiatives
- Increasing cross-cultural understanding among local partners in order to address disparities in health
- Addressing the complex health priorities identified by communities working in partnership with their local health departments
- Promoting policies that improve public health capacity in California to work more effectively with communities

How can the Partnership for the Public's Health help you address these concerns?

- Identify and address policies that are barriers to improved health for California and its communities
- Facilitate partnerships to develop innovative solutions to public health problems and emerging issues
- Communicate reliable health information to the public and policy makers

Support

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Partnership for the Public's Health

Colorado Turning Point

Collaborating for a New Century in Public Health

A strong public health system is crucial for protecting and improving the health of Americans.

Colorado's Public Health

In an otherwise healthy state, the magnitude of health disparities among racial and ethnic groups is staggering. African Americans, American Indians, and Latinos/as in Colorado experience higher rates of disease, disability, and death than the general population. These disparities cost health care dollars, productivity, and future contributions to family and community.

With bioterrorism threats and emerging diseases, we collectively must ensure that all Colorado communities are prepared and protected. Public health and community based organizations need sustained support in working together on health promotion, disease prevention, and emergency preparedness.

All people, regardless of race and ethnicity, should have an equal opportunity to be healthy.

For more information

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What is Colorado Turning Point?

The national Turning Point Initiative aims to transform and strengthen the public health system in the United States by making it more community based and collaborative. Toward this goal, Colorado Turning Point is forging new partnerships to ensure that the state's minority communities are not left behind. The elimination of health disparities must be a top priority for health professionals, policy makers, and communities, so that together we may work toward a solution.

How is Colorado Turning Point improving public health for all?

- Tracking health issues and reporting differences in health by race and ethnicity
- Educating affected communities, health systems, and policy makers on the magnitude of health disparities and their root causes
- Convening traditional public health stakeholders and community-based organizations to address complex public health issues
- Making data, information, technical assistance, and other types of support available to community-based organizations and the public
- Building leaders among minority health professionals through direct training and mentoring, and promoting workforce diversity to improve the qality of public health services
- Endorsing the need to promote social justice strategies that will eliminate differences in health

What can Colorado Turning Point help you do?

- Engage minority communities in assessing local public health needs and defining priorities
- Identify barriers to community health including differential access to health care and other health promoting systems
- Educate minority constituencies about their health status and community resources
- Consider policies that will level the playing field for minority communities

Support

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Colorado Turning Point

Illinois Turning Point

Collaborating for a New Century in Public Health

A strong public health system is crucial for protecting and improving the health of Americans.

Illinois' Public Health

Illinois' ten leading causes of death contributed to more than 84,000 deaths in 2000. Many of those causes, including heart disease, cancer, accidents, diabetes, and liver disease are strongly associated with lifestyle and social factors. As many as one half of those deaths could have been prevented.

The least costly and most effective way to improve health today is to prevent disease and disability, before it occurs.

Poor health and early death do not affect all Illinoisans the same. The difference in the rates of premature death between blacks and whites is the largest in the country.

Illinois' efforts to improve health are fragmented among multiple state agencies and across the private and nonprofit sectors. Local level partnerships vary greatly in their resources and capabilities.

The complex issues that underlie preventable health problems in Illinois require a public health system prepared to address the range of issues that most influence community health.

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What is Illinois Turning Point?

The national Turning Point Initiative aims to transform and strengthen the public health system in the United States by making it more community based and collaborative. In Illinois, Turning Point is known as Public Health Futures Illinois, a partnership of over 8 public, private, and voluntary organizations seeking to improve health through prevention by enhancing community and state public health systems serving the people of Illinois.

How is Turning Point improving public health through Public Health Futures Illinois?

- Engaging a broad range of public health interest groups in partnership to identify and address gaps and weaknesses in the public health system. Partners include representatives from the insurance industry, academia, rural health, the hospital association, and the Red Cross who are committing time and resources to improving the health of Illinoisans.
- Mobilizing collective action to advocate for improved public health policies and expanded public health resources that respond to the uniqe needs of the people of Illinois.
- Educating the public and policy makers on the complex, primary causes of poor health for Illinois residents and promoting strategies to address them.
- Supporting the development of local community health partnerships to identify and address local health status and health systems priorities through training, technical assistance, and policy development.

What can Illinois Turning Point help you do?

- Engage communities in assessing local public health needs, defining priorities, and supporting them in implementing innovative strategies to address community needs
- Mobilize partners in various sectors to develop and advocate for new policies, including promoting and expanding prevention as a critical strategy for saving public and private health care dollars
- Research and provide relevant statistics on the health status of Illinoisans and related health system issues

Support

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Public Health Futures
ILLINOIS

A strong public health system is crucial for protecting and improving the health of Americans.

Kansas' Public Health

The leading causes of death disproportionately affect racial and ethnic minorities in Kansas. Hispanic/Latino Kansans have an 83% higher death rate from diabetes than the general population. African Americans have twice the rate of low birth weight babies and infant deaths. Understanding the effect of economics, access to health services, geography, and having good data are key factors in improving Kansans' health.

Local public health departments provide important services and protections in the public's interest. In 105 counties, 99 local health departments serve the public, but the public health workforce is strained. In a rural state such as ours, ensuring that we use every available partner in the system is critical.

Using data to make informed decisions in times of limited resources has never been more important. Information is at the core of strengthening Kansas' public health system.

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Kansas Turning Point

Collaborating for a New Century in Public Health

What is Kansas Turning Point?

The national Turning Point Initiative aims to transform and strengthen the public health system in the United States by making it more community based and collaborative. In Kansas, the Turning Point Initiative facilitated a Public Health Improvement planning process that identified a number of priority areas where attention was needed to ensure optimal public health for Kansas. Turning Point then provided funding to enable the state to take important action steps on some of these priorities.

How is Kansas Turning Point improving public health?

- Improving linkage of health data sources for public health planning and action to address health disparities
- Supporting a new training program for local leaders to improve their ability to use health data to affect public health improvement
- Linking state and community health efforts aimed at eliminating health disparities among Kansas racial and ethnic minority populations
- Catalyzing a Kansas public health workforce initiative that resulted in the Kansas Public Health Certificate program, a model program to improve the skills of local and state public health personnel
- Joining with the Kansas Health Foundation to expand the capacity of the Kansas Integrated Public Health System, an information system for local public health departments
- Facilitating discussion regarding health policy changes necessary to meet public health needs in the future

What can Turning Point help you do?

- Serve as a reliable source of information from around the nation about innovative programs being undertaken to improve the health of the public
- Provide up-to-date, accurate information regarding health status and health disparities among racial and ethnic minorities in Kansas
- Showcase effective partnerships that deliver quality public health and preventive medical services while meeting the needs of those with and without health insurance

Support

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KANSAS DEPARTMENT OF HEALTH & ENVIRONMENT KDHE

Louisiana Turning Point

Collaborating for a New Century in Public Health

A strong public health system is crucial for protecting and improving the health of Americans.

Louisiana's Public Health

Louisiana's public health system suffers from a lack of adequate funding and resources—creating an environment in which it is difficult to set new health policies— and a lack of effective cooperation among organizations that provide health care.

For a decade, Louisiana has consistently ranked among the lowest 10 states for the health of its residents. Louisiana also has some of the highest levels in the US of unemployed and uninsured workers, and people with chronic diseases.

Organizations and individuals invested in the public's health in Louisiana must coordinate efforts to maximize resources and create innovative systems of delivery to improve the health of those who live in our state.

What is Louisiana Turning Point?

The national Turning Point Initiative aims to transform and strengthen the public health system in the United States by making it more community based and collaborative. The Louisiana Turning Point Partnership, formed in 1998, helps communities make beneficial partnerships with local sectors to address their public health needs. It is housed at the Louisiana Public Health Institute.

How is Louisiana Turning Point improving public health?

- Creating the Community Capacity Enhancement Center to help communities gain the knowledge and skills necessary to influence public health policy and successfully develop and sustain local health initiatives
- Convening organizations engaged in improving the public's health in forums called the Access to Care Congress, which has allowed for comprehensive problem-solving among local organizations to ensure access to care in the state
- Improving effective policy development in Louisiana by creating the Louisiana Public Health Policy Institute and by facilitating a conference to help communities across the state learn about affecting the development of local and state public health policy
- Conducting the first comprehensive assessment of Louisiana's public health environment, culminating in the Louisiana Public Health Improvement Plan of June 2000
- Providing training and technical support for 29 community health Delta Parishes on effective leadership and successful grant administration

What can Louisiana Turning Point help you do?

- Expand access to health care for the uninsured and under-insured in Louisiana communities
- Increase community leadership development and mobilization for improving local public health systems

For more information

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Support

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Maine Turning Point

Collaborating for a New Century in Public Health

A strong public health system is crucial for protecting and improving the health of Americans.

Maine's Public Health

Heart disease is the leading cause of death, illness, and health care costs for citizens of Maine.

Unlike almost all other states, Maine does not have a systematic, statewide organized public health structure at the local or regional level

Strong public health systems have the ability to improve the lives of the public, protect the public's health, and ensure the delivery of the essential public health services

Citizens of Maine should have access to the benefits of public health based in a strong system.

Maine needs a public health infrastructure at the regional level that can complement the state system and local activities

For more information

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What is Maine Turning Point?

The national Turning Point Initiative aims to transform and strengthen the public health system in the United States by making it more community based and collaborative. The Maine Turning Point project has more than 30 partners working together to build a strong public health system for people in Maine. These partners are convened by the Maine Center for Public Health, a private, nonprofit organization established by the Maine State Legislature in 1996 to improve the health of Maine citizens.

How is Maine Turning Point improving public health?

- Promoting access and coordination of public health services throughout Maine communities to better protect the health of local citizens
- Convening community partnerships across the state to assure the coordination of community-wide public health prevention and response programs
- Creating new public health leaders at the local level through a formal mentoring program that matches experienced community health coalition leaders with emerging local leaders
- Providing and expanding education for public health professionals to ensure a skilled and competent workforce
- Linking public health efforts to form a regional approach that improves the coordination of public health data sharing, training opportunities, emergency response, and other emerging public health issues between state level authorities and local communities

What can Maine Turning Point help you do?

- Provide information to support the development of public health policy
- Understand the issues related to the organization of public health at the sub-state level
- Improve the health of Maine residents through support of a regional structure, based on the configuration of regions for bioterrorism preparedness, to coordinate public health activity in communities

Support

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MAINE Turning Point

Minnesota Turning Point

Collaborating for a New Century in Public Health

A strong public health system is crucial for protecting and improving the health of Americans.

Minnesota's Public Health

Minnesota has a comprehensive public health system based on a strong partnership between state and local governments.

Minnesota ranks second in the U.S. in good health and quality of life due to strong policies and partnerships related to safe food and water and healthy pregnancies and births. All Minnesotans have not benefited equally, however, from the systems that promote good health since Minnesota residents also have some of the widest gaps of any state in the country in health status between white and nonwhite populations.

Many public health problems, such as racial and ethnic health differences, cannot be resolved by a single agency or sector acting alone.

To maximize the effectiveness of the public health system and the health of **all** Minnesota residents, partnerships must be strengthened with health care systems, communities of color, community-based organizations, educational institutions, and others.

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What is Minnesota Turning Point?

The national Turning Point Initiative aims to transform and strengthen the public health system in the United States by making it more community based and collaborative. Turning Point in Minnesota is exemplified by the Minnesota Health Improvement Partnership, a collaborative of public, private, and nonprofit sector organizations that are committed to improving the health of Minnesotans.

How is Turning Point's Minnesota Health Improvement Partnership improving public health?

- Convening people from many sectors who are collaborating to improve the public's health. As a result, partner organizations are reporting significant changes in the way they do business.
- Engaging private and nonprofit sectors in working with state and local public health agencies on difficult crosscutting policy decisions. Minnesota's Blue Cross Foundation is redesigning its funding guidelines in order to address inequities in health as a result of this Partnership's work in linking social and economic conditions and health.
- Influencing policy direction in addressing health issues. For example, the Greater Twin Cities United Way reports using new strategies to increase community involvement and that the work of the Minnesota Health Improvement Partnership's work influences which key public health policy issues to address.
- Increasing the understanding and commitment to public health work among diverse partners in public health.
- Providing direction to the work of public health partners. The Center for Population Health in Minnesota's seven-county metro area, for example, uses the statewide goals developed by the partnership to develop its annual work plan.

What can Minnesota Turning Point help you do?

- Mobilize partnerships to develop innovative strategies to address high-priority health needs
- Identify strategies that build on the strengths of the public, private, and nonprofit sectors sharing resources and approaches that improve health in complementary ways

Support

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Missouri Turning Point

Collaborating for a New Century in Public Health

A strong public health system is crucial for protecting and improving the health of Americans.

Missouri's Public Health

In 1999, the United Health Foundation State Health Rankings ranked Missouri the 26th healthiest state in the country. By 2002 Missouri had fallen to 32nd in overall key health indicators. Missourians are experiencing a significant increase in the number of deaths due to heart disease, cancer, and infectious disease. Combined with increases in smoking, children living in poverty, and a general lack of health insurance, the health of Missourians is in danger.

A shortage of resources at all levels of government has devastated the public health workforce and its capacity to respond at the very time that emerging threats to the public's health require advances in public health science, training, and leadership.

Sustained, comprehensive attention and support is needed for improving Missouri's health and the ability of its workforce to address priority health issues and be prepared for public health emergencies.

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THE ROBERT WOOD JOHNSON FOUNDATION

What is Missouri Turning Point?

The national Turning Point Initiative aims to transform and strengthen the public health system in the United States by making it more community based and collaborative. Turning Point in Missouri has created the Missouri Institute for Community Health (MICH)a multi-sector organization that facilitates planning and decision making among health care providers, the private sector, community colleges, universities, health and human service associations, and state and local government.

How is Turning Point improving the lives of Missourians through MICH?

- Encouraging and supporting comprehensive community efforts to promote health and target the root causes of preventable disease—efforts such as county-wide health assessment, planning, and community prioritizing
- Supporting efforts to increase the skills and capacity of Missouri's public health workforce
- Fostering the use of standards of practice in the performance of essential public health activities at the community level so that communities are guaranteed their right to comprehensive public health service and protection
- Supporting approaches that improve public health at the level of more efficient systems
- Utilizing diverse partnerships to maximize shared resources and decision making

What can Turning Point's MICH help you do?

- Communicate new and emerging public health issues to the public health workforce and the people of Missouri
- Showcase Missouri as a model state for voluntary standardization of local public health agencies
- Convene community health systems together with local residents to improve public health responsiveness at the local level

Support

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Montana Turning Point

Collaborating for a New Century in Public Health

A strong public health system is crucial for protecting and improving the health of Americans.

Montana's Public Health

Montanans do not have access to a consistent set of public health services across the state. Only half of the state's local public health departments are meeting at least 50% of the standard community services expected of public health systems.

In 2000, Montana had one of the highest percentages of residents without health care coverage and had the lowest average annual pay of any state in the country. At the same time, obesity is on the rise, bringing increases in diabetes, heart disease, disabilities and health care costs throughout the state.

Montana residents face serious public health challenges, including the need for protection from emerging public health concerns, such as West Nile virus and bioterrorism threats.

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THE ROBERT WOOD JOHNSON FOUNDATION

What is Montana Turning Point?

The national Turning Point Initiative aims to transform and strengthen the public health system in the United States by making it more community based and collaborative. Montana's Turning Point Initiative has defined the public health system to include traditional state and local public health agencies and a wide variety of community partners. These partners are currently engaged in implementing a strategic plan to improve our public health system and the health of our citizens.

How is Montana's Turning Point Initiative improving public health?

- Implementing *A Strategic Plan for Public Health System Improvement in Montana* in collaboration with local public health agencies and other community partners to ensure that citizens across the state have access to a consistent set of public health services and expertise
- Promoting local partnerships with public health agencies working in coordination with hospitals, health care workers, nonprofit agencies, county governments, business, faith communities, and others to protect and promote the public's health
- Providing training and education for public health workers through the Montana Public Health Training Institute in order to supply local health settings with staff trained to respond to new and emerging public health issues and emergencies
- Facilitating communication among public health system partners, including building capacity in telecommunications and computer technology for increased efficiency and effectiveness throughout the public health system.
- Developing a performance management system for qality improvement and system accountability

What can Montana Turning Point help you do?

- Work to ensure Public Health Emergency Preparedness and Response efforts address all types of emergencies to better serve the public on a daily basis
- Assist in the evaluation and improvement of public health services to ensure funding is used appropriately
- Improve communication among local public health agencies to assure public health concerns are addressed with a coordinated statewide approach
- Serve as a reliable source of information on the status of the public's health in Montana

Support

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Nebraska Turning Point

Collaborating for a New Century in Public Health

A strong public health system is crucial for protecting and improving the health of Americans.

Nebraska's Public Health

In 2000, Nebraska's public health system was weak, fragmented, uncoordinated, and under-funded. It had 16 local health departments that covered 22 of the state's 93 counties. With state funding from the Tobacco Settlement Fund, 16 new regional local public health departments were created and now cover all but one county.

Despite this expanded capacity, the public health system faces many challenges, such as major differences between the health of Nebraska's general population and its racial/ethnic minority populations, as well as obesity among all Nebraskans.

Nebraska high school students are twice as likely to drink and drive as their counterparts nationwide. Many Nebraskans are uninsured or under-insured, limiting their access to timely preventive and medical services.

Dealing with these complex challenges requires local public health departments that collaborate with diverse community partners to develop innovative solutions.

For more information

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What is Nebraska Turning Point?

The national Turning Point Initiative aims to transform and strengthen the public health system in the United States by making it more community based and collaborative. Turning Point in Nebraska provided the stimulus for building and funding Nebraska's first comprehensive public health system at the community level.

How is Nebraska Turning Point improving public health?

- Supporting the development of 16 new regional public health departments that have adopted a broad definition of health extending beyond medical care
- Encouraging collaborative partnerships at the local and state levels that include hospitals, physicians, nonprofit agencies, county governments, businesses, schools, faith communities, and environmental health organizations and are:
  - Developing strategic community plans that address local problems such as teenage smoking, obesity, diabetes, and injuries
  - Modifying outdated and fragmented laws that protect the public's health
  - Addressing the health disparities of racial/ethnic minorities
- Protecting the public from and planning for bioterrorism, infectious disease, contaminated food, and other emergency events
- Providing training opportunities to improve the skills and abilities of the public health work force

What can Nebraska Turning Point help you do?

- Organize coalitions that identify priority health issues, recognize health threats, assess health service needs, and are accountable to local communities.
- Mobilize community partnerships to develop new policies and innovative strategies to address high priority health needs.
- Work with community coalitions to develop plans for bioterrorism events and other emergency conditions.
- Assist in the evaluation of programs and policies to determine the effectiveness and qality of health programs and services.

Support

The Turning Point Initiative is funded by The Robert Wood Johnson Foundation. The National Program Office is located at the University of Washington School of Public Health and Community Medicine. Contact the National Program Office at 206-616-8410 or visit www.turningpointprogram.org.

Nevada Turning Point

Collaborating for a New Century in Public Health

A strong public health system is crucial for protecting and improving the health of Americans.

Nevada's Public Health

The population of Nevada increased more than 66 percent between 1990 and 2000, but Nevada has seen no increase in state spending for health promotion and disease prevention since 1992

Nevada's smoking rates and health problems from tobacco are among the highest in the nation. Yet Nevada is one of the few states that does not allow local governments to regulate tobacco

At double the national rate, Nevada has the highest proportion of suicides in the nation

Nevadans report poorer health than the rest of the nation and engage in more risk behaviors that contribute to poor health

Of Nevada's 17 counties, 15 have no local health department. Nevada has no school of public health to educate new and existing public health workers

Nevada needs an improved public health system that promotes health and prevents disease

For more information

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What is Nevada Turning Point?

The national Turning Point Initiative aims to transform and strengthen the public health system in the United States by making it more community based and collaborative. Nevada Turning Point listens to, educates, and mobilizes Nevadans to improve the health of their communities and strengthen the public health system so it can respond to the emerging public health challenges.

How is Nevada Turning Point improving public health?

- Developing a Citizens' Public Health Network to establish connections among Nevadans and their organizations to increase collaboration and success in achieving community improvements
- Joining with the Utah Department of Health to create the Great Basin Public Health Leadership Institute to develop Nevada's workforce and build leadership among public health professionals and community leaders
- Improving policy and programming related to tobacco use and suicide prevention as priority public health issues
- Collaborating with communities and civic organizations to assess local needs and to develop local public health systems in Nevada's rural counties that will address local health priorities and emerging public health issues
- Offering community education on public health issues and the political process to give Nevadans the information and skills they need to improve their communities' health
- Educating elected officials and government managers about public health issues so they can make decisions that protect the health of their constituents and put scarce resources to best use

What can Nevada Turning Point help you do?

- Mobilize a network of public health organizations and partners throughout the state in order to convey information on health issues and respond to emerging problems
- Engage communities around their unique high priority health issues
- Improve the health of Nevadans through effective health promotion and disease prevention programs and policies
- Strengthen Nevada's state and local public health organizations to improve emergency readiness and accountability

Support

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NEVADA PUBLIC HEALTH FOUNDATION

New Hampshire Turning Point

Collaborating for a New Century in Public Health

A strong public health system is crucial for protecting and improving the health of Americans.

New Hampshire's Public Health

New Hampshire consistently rates as one of the healthiest states in the country when measured by such factors as child health, health care access, and health care quality.

Statewide average statistics, however, mask disparities in the health and quality of life of some of New Hampshire residents.

New Hampshire has a very fragmented local public health system. The 234 appointed health officers, often employed as building inspectors and with no training in health, represent the health department in most New Hampshire towns.

By default, police, fire, school nurses and nonprofit health and human service providers fulfill roles more typically assigned to local public health officials.

There is a lack of cohesive disease control and surveillance at the local level, a failure to identify and maximize statewide assets related to public health, and a shortage of public health resources coming into the state.

For more information

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THE ROBERT WOOD JOHNSON FOUNDATION

What is New Hampshire Turning Point?

The national Turning Point Initiative aims to transform and strengthen the public health system in the United States by making it more community based and collaborative. In New Hampshire, the Turning Point partnership consists of the New Hampshire Public Health Network. The Network originated as four regional community collaboratives and two city health departments working to make a more effective and responsive local public health system. Building on these successes the Public Health Network has continued to expand and will be made up of 10 regional collaboratives by spring 2003, representing 60% of New Hampshire residents.

How is New Hampshire Turning Point improving public health?

The New Hampshire Public Health Network has created effective community collaboratives to maximize limited resources to improve public health. Together, the Network collaboratives are:

- Assessing local needs and identifying local public health system gaps for which regional stakeholders are working with state partners to provide disease monitoring, technical assistance, training in bioterrorism response, and installing unique regional models tailored to local needs
- Mobilizing public health leaders and existing resources at the community level to develop coordinated responses to community and regional public health needs
- Developing strategic linkages with businesses, schools, hospitals, human service providers and faith communities to assess and plan for improvement of overall health status
- Sharing resources to create economies of scale, reduce potential for redundancy, and improve overall public health system effectiveness

What can New Hampshire Turning Point help you do?

- Create a New Hampshire Public Health Resource Team as a link between elected officials and the providers and collaborative partnerships in local communities
- Increase direct contact with constituents regarding priority public health issues in their communities
- Identify barriers to community health, including lack of health care coverage and services, poverty, attitudes and belief systems, and environmental factors
- Strengthen regional partnerships that share in planning, building, and maintaining healthy communities.

Support

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New Jersey Turning Point

Collaborating for a New Century in Public Health

A strong public health system is crucial for protecting and improving the health of Americans.

New Jersey's Public Health

New Jersey's 523 boards of health and 115 local health agencies serve more than 500 municipalities. More than 80% of the local health agencies are municipal with about 5% of these structured as regional health commissions, and 12% as county agencies.

New Jersey faces many public health challenges. Our state has intolerably high numbers of HIV/AIDS cases, high rates of infant deaths particularly among African Americans, and increasing cases of asthma. In addition, New Jersey is facing an epidemic of childhood obesity and inadequate access to mental health services.

An essential element missing in the New Jersey public health system is a structure to link community needs to existing public health services. New Jersey's most vulnerable communities must have access to and involvement in developing solutions for the priority health problems.

For more information

[redacted]

THE ROBERT WOOD JOHNSON FOUNDATION

What is Public Health: C.A.R.E. in New Jersey?

The national Turning Point Initiative aims to transform and strengthen the public health system in the United States by making it more community based and collaborative. In New Jersey, the national Turning Point Initiative is affiliated with Public Health: C.A.R.E.—Crafting A Restructured Environment. C.A.R.E. aims to transform and strengthen New Jersey's public health system by making it more consistent, efficient, and accessible to the community.

How is Public Health: C.A.R.E. improving public health?

- Developing public-private partnerships to bring both community and governmental resources to bear on public health problems and health policy outcomes that improve health status
- Convening the Pediatric State-wide Leadership Council in 2003 by bringing physicians, nurses, public health professionals, mental health professionals, and school-based health practitioners together to focus on improving systems that can prevent childhood obesity, increase mental health services for children&adolescents, and improve New Jersey's immunization practice
- Building a new constituency for health promotion and disease prevention by linking community agencies, professional organizations, local health departments, and medical professionals

What can Public Health: C.A.R.E. help you do?

- Identify the public health priorities and needs facing New Jersey communities
- Generate practical solutions to public health problems by applying scientific expertise to health policy development
- Build partnerships among business, public health, medical, and community-based organizations to solve public health priority issues
- Create efficiency and accountability in public health systems, programs, and services by leveraging private sector support

Support

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Public Health: *C.A.R.E.*
"Crafting A Restructured Environment"

A strong public health system is crucial for protecting and improving the health of Americans.

New York's Public Health

New York's 14,000 public health workers, within the state health department and 58 local health departments are at the front lines to prevent epidemics and the spread of disease. They also protect against environmental hazards, promote and encourage healthy lifestyles, assure high-quality accessible health services, and respond to community disasters and aid in recovery.

The nearly 19 million people who live in New York State urgently need a public health workforce trained in emerging public health issues including biological, chemical, and radiological emergency preparedness.

New Yorkers include 12% who are not citizen residents and a diverse mix of racial and ethnic groups. Disease prevention and health promotion for New Yorkers requires communicating effectively across cultures and among diverse populations.

Local health departments need resources and training to strengthen their capacities to prepare for public health emergencies among diverse populations throughout the state.

For more information

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THE ROBERT WOOD JOHNSON FOUNDATION

New York Turning Point

Collaborating for a New Century in Public Health

What is New York Turning Point?

The national Turning Point Initiative aims to transform and strengthen the public health system in the United States by making it more community based and collaborative. New York's Turning Point Initiative is strengthening the capacity of the public health workforce and community health coalitions by increasing public health knowledge, skills and program effectiveness. The timely successes of Turning Point's collaborative partnerships and development of a skilled workforce in New York are substantially improving the state's public health responsiveness to bioterrorism and other emerging public health threats.

How is the New York State Turning Point Initiative strengthening public health?

- Enhancing partnerships with local public health agencies, schools of public health, professional health care and community-based organizations to identify and address the training and continuing education needs of the public health workforce and community health coalitions.
- Co-sponsoring the *Third Thursday Breakfast Broadcasts (T2B2)*, a nationally recognized, monthly one-hour satellite broadcast series featuring experts on current public health issues. These broadcasts strengthen skills and provide essential information to communities for addressing emerging public health issues such as emergency preparedness, bioterrorism, and West Nile virus.
- Developing an online course providing training for public health nurses and an orientation course for new local health commissioners and directors.
- Improving knowledge, skills and access to community health data and information needed to assess and address priority health issues in communities.
- Strengthening collaboration between local hospitals and public health agencies, which is necessary to assess and address community health issues and to prepare for potential public health emergencies.

How can the New York State Turning Point Initiative help you?

- Identify high priority public health needs and resources in your communities
- Assess and address the ongoing training needs of New York's public health workforce
- Provide access to high qality training and material on emerging public health issues such as emergency preparedness and bioterrorism
- Assure that your public health workers are prepared and relate effectively to important partners such as hospitals and first responders

Support

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New York State Community Health Partnership

North Carolina Turning Point

Collaborating for a New Century in Public Health

.A strong public health system is crucial for protecting and improving the health of Americans.

North Carolina's Public Health

North Carolina ranks among the country's bottom third in overall health of its residents. Chronic diseases, which are largely preventable, consume 75% of North Carolina's health care dollars.

Tobacco use alone costs North Carolinians $4.8 billion annually in both direct and indirect costs.

At the same time less than 1% a year of the state's total health care dollars goes to support health promotion and disease prevention.

Preventing illness and disability associated with preventable risks requires complex solutions and the commitment and investment of people and organizations from many sectors.

North Carolina needs a consistent investment in community and statewide activities such as community assessment, the monitoring of health trends, and local response to priority health issues in order to fully promote and protect the health of its residents.

For more information

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What is North Carolina Turning Point?

The national Turning Point Initiative aims to transform and strengthen the public health system in the United States by making it more community based and collaborative. North Carolina's Turning Point is expanding and enhancing existing state and local partner organizations working to transform the overall system for meeting North Carolinians' health needs. Turning Point contributes to public health improvement through its support of Healthy Carolinians, North Carolina's network of locally based, public-private partnerships to improve and protect the public's health.

How is North Carolina's Turning Point improving public health?

- Fostering the use of standards of practice in the performance of essential public health activities at the community level so that communities are guaranteed their right to comprehensive public health service and protection
- Providing crisis, emergency, and risk communication training and infrastructure development for the state's Office of Public Health Preparedness
- Providing state and local training to apply techniques of social marketing in public health programs in efforts to change health risk behaviors
- Creating educational programs and identifying best practices for public health partnerships to eliminate health disparities in North Carolina communities

What can North Carolina's Turning Point help you do?

- Engage communities in assessing local public health needs, defining priorities, and mobilizing resources
- Identify barriers to community health, including access to affordable health care
- Link community-based health assessment with state-level planning and resource allocation
- Improve responsiveness for public health emergencies
- Facilitate private sector involvement and commitment in the public's health

Support

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HEALTHY CAROLINIANS

Oklahoma Turning Point

Collaborating for a New Century in Public Health

A strong public health system is crucial for protecting and improving the health of Americans.

Oklahoma's Public Health

With health departments in 69 of its 77 counties, Oklahoma has one of the best public health infrastructures in the nation.

Unfortunately, our public health infrastructure has not resulted in a healthier population. Oklahoma ranks 46th in the United Health Foundation 2002 State Health Rankings. Oklahoma ranks among the worst in infectious diseases, death rates, and teenage births. Oklahoma's death rates for heart disease, cancer, injuries, stroke, and emphysema are higher than the national average.

Oklahoma citizens are overburdened with more than their share of disability and unnecessary death.

An essential element missing in how public health deals with these problems in Oklahoma is community-based decision making.

Oklahoma's communities can and must voice their community health needs and take an active role in making public health decisions as equal partners.

For more information

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What is Oklahoma Turning Point?

The national Turning Point Initiative aims to transform and strengthen the public health system in the United States by making it more community based and collaborative. Turning Point in Oklahoma has more than 40 partnerships across the state working to strengthen Oklahoma's public health infrastructure through community based action in order to respond to the challenge of protecting and improving the public's health in the 21st century.

How is Oklahoma Turning Point improving public health?

- Promoting a community-based approach in public health decision-making through 40 local partnerships
- Increased cooperation of key state and local partners that successfully addressed secondhand smoke through legislation
- Developing partnerships with the state, county agencies, and communities to *assess local public health needs and develop local solutions*
- Local partnerships developing Community Health Improvement Plans
- Established a resource center for data collection and analysis that will help communities implement population-wide services at the local level

What can Oklahoma Turning Point help you do?

- [illegible] communities in assessing local public health needs and [illegible]ing priorities
- Identify barriers to community health, including lack of health care coverage and services, poverty, attitudes and belief systems, and environmental factors
- Strengthen partnerships that share in planning, building, and maintaining healthy communities
- Improve the public's health through health promotion and disease prevention initiatives and policy change

Support

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OKLAHOMA Turning POINT

Oregon Turning Point

Collaborating for a New Century in Public Health

A strong public health system is crucial for protecting and improving the health of Americans.

Oregon's Public Health

Assessments of Oregon's public health system in 2000 and 2002 showed substantial progress, particularly in the prevention of infectious disease. Despite new funding for bioterrorism response readiness, gaps exist in public health services. Other vital public health functions needed by the public still remain, but without adequate resources.

Oregon's public health system provides important services and protections in the public interest. Coalitions, networks, and clinics have demonstrated that they can come together in partnership with state and other agencies to share information.

Safeguarding the public's health by using information to make informed decisions in times of limited resources has never been more important. Tobacco use was identified as the leading cause of preventable deaths in Oregon, and a voter-approved initiative provided funding over the past five years that led to a dramatic decrease in tobacco use by adults and teenagers. Obesity and cancer are the next leading causes of preventable Oregon deaths. Investments in public health can prevent these deaths.

For more information

[redacted]

What is Oregon Turning Point?

The national Turning Point Initiative aims to transform and strengthen the public health system in the United States by making it more community based and collaborative. Turning Point in Oregon facilitated the creation of the Oregon Public Health Improvement Plan, which identified priority areas needing public health attention. Turning Point now enables the state to take important action steps on recommendations from the plan that will improve the health of Oregonians.

How is Oregon Turning Point improving public health?

- Supporting collaborative partnerships at local and state levels that include hospitals, physicians, nonprofit agencies, county governments, businesses, schools, faith communities, and environmental health organizations
- Modifying outdated and fragmented laws that protect the public's health
- Developing standards for local and state public health systems to ensure adeqate public health services to all Oregonians
- Convening health-related organizations to identify health policy changes necessary to meet public health demands in Oregon for the future health and safety of Oregonians

What can Turning Point help you do?

- Mobilize community partnerships to develop new policies and innovative strategies to address high-priority health needs
- Work with public safety agencies and community coalitions to develop plans for bioterrorism events and other emergency conditions
- Showcase effective partnerships that deliver qality public health and preventive services based on assessment and specific needs identified by local communities
- Ensure an effective, well-prepared public health workforce to promote and protect the health of Oregonians
- Provide important data and information to members of Congress

Support

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turning point

South Carolina Turning Point

Collaborating for a New Century in Public Health

A strong public health system is crucial for protecting and improving the health of Americans.

South Carolina's Public Health

South Carolina leads the nation in many health indicators, from cardiovascular death rates to HIV/AIDS. Particularly troubling are the persistent health disparities between white and African American residents. These indicators and disparities relate to complex community problems associated with lifestyles, the environment, economics, and access to care.

Improving community health requires local public health leadership to support community planned health initiatives.

State budget cuts, categorical federal funding, and new demands for emergency preparedness are stressing the existing structure of state, district, and county public health offices and limiting their ability to respond to local communities' unique needs.

Community partnerships are a critical ingredient for improving community health. We must link community wisdom and professional expertise with the political will to make the necessary changes.

For more information

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THE ROBERT WOOD JOHNSON FOUNDATION

What is South Carolina Turning Point?

The national Turning Point Initiative aims to transform and strengthen the public health system in the United States by making it more community based and collaborative. In South Carolina, Turning Point is a collaborative process that strengthens the state's capacity to protect and improve the public's health by merging professional expertise and community wisdom with political will. Partners representing a diverse group of public, private, state, and local organizations guide this process.

How is South Carolina Turning Point improving public health?

- Supporting community-driven health planning that uses data effectively, engages ethnic and minority communities, incorporates environmental factors, and builds community and local health department capacity in areas such as Horry, Georgetown, Hampton, and Orangeburg
- Improving working relationships and building effective partnerships among agencies and organizations working with and within communities to promote health
- Providing critical training for public health professionals and lay leaders to eqip them with appropriate leadership skills and the knowledge to improve and protect health in their communities
- Identifying health and environmental data that communities need to inform community action for health improvement and protection
- Creating and sustaining state level commitments to innovation related to improving public health involvement at the local level, despite the state's worst financial crisis in decades

What can South Carolina Turning Point help you do?

- Access communities that have assessed and prioritized their local public health needs through a nationally recognized, inclusive strategic planning process
- Improve the health of South Carolinians through the support and leadership development of professionals and lay community partners invested in developing a stronger public health system
- Engage professional and lay community leaders from across the state, who can share first hand their successes and challenges with merging professional expertise, community wisdom, and political will to improve their community's health

Support

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Turning Point

A strong public health system is crucial for protecting and improving the health of Americans.

Virginia's Public Health

[illegible] is regarded as a safe and healthy place to live, but troubling signs are ahead

Virginia spends $300 million per year to cover inpatient treatment for preventable injuries

The state loses $2.8 billion annually in direct medical and indirect costs related to diabetes

More than one million Virginians are [illegible] basic health insurance

Millions more are sliding from or on the path to serious health problems that could be prevented or lessened through [illegible] intervention

In just the past six years, Virginia's overall health status has fallen from 10th in the nation to 19th

The Commonwealth and its citizens need and deserve a healthy, productive future

Effective public private partnerships that reflect diverse sectors from the community are a positive step we can take to ensure Virginia's future

For more information

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THE ROBERT WOOD JOHNSON FOUNDATION

Virginia Turning Point

Collaborating for a New Century in Public Health

What is Virginia Turning Point?

The national Turning Point Initiative aims to transform and strengthen the public health system in the United States by making it more community based and collaborative. Virginia Turning Point, known as the Virginia Center for Healthy Communities, emphasizes developing tools to help public and private sectors work together to identify needs and implement solutions to community health problems.

How is Turning Point improving community health through the Virginia Center for Healthy Communities?

The health of Virginians improves and the health care costs for the public drops when preventable illnesses are reduced. The Virginia Center for Healthy Communities helps businesses and communities know how to make this happen by:

- Pinpointing the most urgent health issues for a specific population and providing direction on establishing related community health improvement programs
- Linking businesses, communities, and others with partners that will help their programs get started more qickly and work more effectively

The Virginia Center for Healthy Communities promotes collaboration among the business, health care, insurer, civic, education, and public health communities, helping them work together to develop and implement effective community health improvement activities. Among the many ways the Center helps are:

- Community Health Incentives: technical assistance to stimulate partnerships and community health intervention programs
- The Virginia Atlas of Community Health: an in-depth tool that identifies health issues of communitieswith 80 health status indicators, including local rates for key health conditions each of which can be examined for specific demographic groups within a zip code
- Advice for Community Health: a reliable resource for those establishing health improvement programs and for public policy makers designing programs

What can the Virginia Center for Healthy Communities help you do?

- Provide in-depth information on the specific health needs of your constituents
- Serve as a reliable resource of information on health issues and community health needs
- Improve community health through expanded investment and participation by local businesses and other sectors committed to community health development
- Provide the facts and figures needed to weigh the merits of proposed legislative action on health issues.

Support

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Virginia Center for Healthy Communities

West Virginia Turning Point

Collaborating for a New Century in Public Health

A strong public health system is crucial for protecting and improving the health of Americans.

West Virginia's Public Health

West Virginia is the second most rural state in the nation, which increases the importance of strong and coordinated local partnerships.

In 1997, 34 of the 49 local health departments in West Virginia were experiencing severe reduction in services and workforce due to a dramatic decrease in revenue and support.

West Virginia's communicable diseases were being underreported and the need to strengthen surveillance capacity was identified.

Historically, state and local planning efforts have lacked a formal process for setting joint short and long-term priorities.

For more information

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THE ROBERT WOOD JOHNSON FOUNDATION

What is West Virginia Turning Point?

The national Turning Point Initiative aims to transform and strengthen the public health system in the United States by making it more community based and collaborative. In West Virginia, the Turning Point Initiative focuses on improving the performance of and working relationship between state and local governmental public health agencies in order to more effectively address health issues. West Virginia, working with Turning Point partners, is creating processes that measure the performance and effectiveness of public health activities throughout the state.

How is West Virginia Turning Point improving public health?

- Regularly assessing the performance of local public health services through a new accountability structure. This new structure assures West Virginians of standardized care and ongoing improvements to services that protect their health. New performance standards, for example, have already reduced the time it takes to recognize a new infectious disease outbreak in West Virginia.
- Convening active partnerships of representatives from a variety of sectors that have a stake in public health at the local level to share resources and decision making based on local health priorities.
- Supporting community partnerships in developing local policies and revising outdated public health codes. As a result, communities have the legal tools and authority needed to respond qickly in a public health emergency.
- Strengthening the relationship between state and local public health structures through formal working agreements and joint planning and assessment with activities such as the Annual Invitational Roundtable on Public Health.
- Increasing the capability of the public health workforce through the development of standardized job descriptions, orientation programs, and structured job training tools for public health nurses.
- Improving ability to track emerging infectious diseases by developing performance standards, increasing regional and state staff, strengthening laboratory capacity, and providing qarterly trainings.

What can West Virginia Turning Point help you do?

- Monitor the effectiveness and efficiency of public health systems and programs through performance management
- Assess the health of state and community populations to establish priority areas for investment and health improvement

Support

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Wisconsin Turning Point

Collaborating for a New Century in Public Health

A strong public health system is crucial for protecting and improving the health of Americans.

Wisconsin's Transformed Public Health System – A Good Investment

Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the State was developed through the Wisconsin Turning Point Initiative and changes the way we view public health in the state. With a focus on health promotion and disease prevention and the development of new collaborative partnerships, this strategic health plan is a comprehensive analysis of what causes the most death and disease in Wisconsin.

Poor access to health services, inadequate nutrition, exposure to environmental hazards, emerging infectious disease, and other issues are priority areas for intervention if we are to improve the health of Wisconsins.

Wisconsin's public health system must be restructured to eliminate health disparities and protect and promote the health of all. No one sector can guarantee improvements in the health of Wisconsin residents; multi-sector partnerships focused on health promotion and disease prevention are key to our success.

For more information

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THE ROBERT WOOD JOHNSON FOUNDATION

What is Wisconsin Turning Point?

The national Turning Point Initiative aims to transform and strengthen the public health system in the United States by making it more community based and collaborative. Wisconsin's Turning Point Initiative reflects a transformation in the way Wisconsin operates its public health system and addresses its priorities. Maintaining the health of the public was once solely identified as a governmental responsibility, but Turning Point in Wisconsin is helping define more broadly the roles and responsibilities for improving the health of our communities.

How is Wisconsin's Turning Point Initiative improving public health?

- Developing policy recommendations to improve public health laws that provide legal support for the protection of Wisconsins
- Ensuring good management of resources through quality assurance activities with public health partners
- Creating model practices resulting in achievements, such as countywide coalitions that exceeded national early childhood immunization goals and were awarded the first annual federal Protect Award from the Centers for Disease Control and Prevention
- Facilitating innovative state, federal, private partnerships such as the partnership that has made regional dental resources accessible to entire communities
- Expanding academic/community partnerships to advance health throughout the state through the formalization of strong public health partnerships with the University of Wisconsin Medical School and the Medical College of Wisconsin

What can Wisconsin Turning Point help you do?

- Focus policies and resources on the health and system priorities identified in *Healthiest Wisconsin 2010*
- Monitor health improvement in Wisconsin through the evaluation efforts of *Healthiest Wisconsin 2010*
- Showcase and support the replication of effective partnerships in Wisconsin that have received national attention for their achievements
- Mobilize community partnerships to develop new policies and innovative strategies to address high priority health needs

Support

The Turning Point Initiative is funded by The Robert Wood Johnson Foundation. The National Program Office is located at the University of Washington School of Public Health and Community Medicine. Contact the National Program Office at 206-616-8410 or visit www.turningpointprogram.org.

Wisconsin's Turning Point

More About Turning Point

Turning Point also sponsors five National Excellence Collaboratives, in addition to supporting the work of the states described in this publication. The National Excellence Collaboratives are made up of participating Turning Point state members who work in local and state public health settings and also includes representatives from national organizations and federal agencies. The Collaboratives provide an integrated approach to public health system change and have developed tools and resources for practice.

The National Excellence Collaboratives and some of their products

Statute Modernization—providing direction for improving laws that protect the health of the public

- Selected Products: *The Model State Public Health Act,* and *The State Public Health Law Assessment Report*

Information Technology—providing resources for effective communication and access to information

- Selected Products: A national survey on the information technology used by state and local health departments and the *Web-based Public Health Information Systems Catalog*

Social Marketing—providing tools for effective public health communication

- Selected Products: CDCynergy-SOC, a social marketing version of CDC's CDCynergy, *The Social Marketing Resource Guide, Social Marketing 101,* and *Lessons from the Field*

Leadership Development—providing skills for working collaboratively in public health

- Selected Products: *Collaborative Leadership and Health: A Review of the Literature* and a curriculum for collaborative leadership

Performance Management—providing a way to measure and improve public health systems

- Selected Products: *Performance Management in Public Health: A Literature Review; From Silos to Systems: Performance Management in Public Health; From Silos to Systems: A Performance Management Toolkit and Implementation Guide*

The National Excellence Collaboratives are also joined in this work by many national public health partners—the Centers for Disease Control and Prevention, the National Association of County and City Health Officials, the American Public Health Association, the Association of State and Territorial Health Officials, the National Association of Local Boards of Health, the National Network of Public Health Institutes, the National Public Health Leadership Development Network, the National Council of State Legislators, the National Governors Association, the Public Health Foundation, and others.

Information, publications, and further descriptions of the National Excellence Collaboratives and other Turning Point projects can be found at www.turningpointprogram.org.

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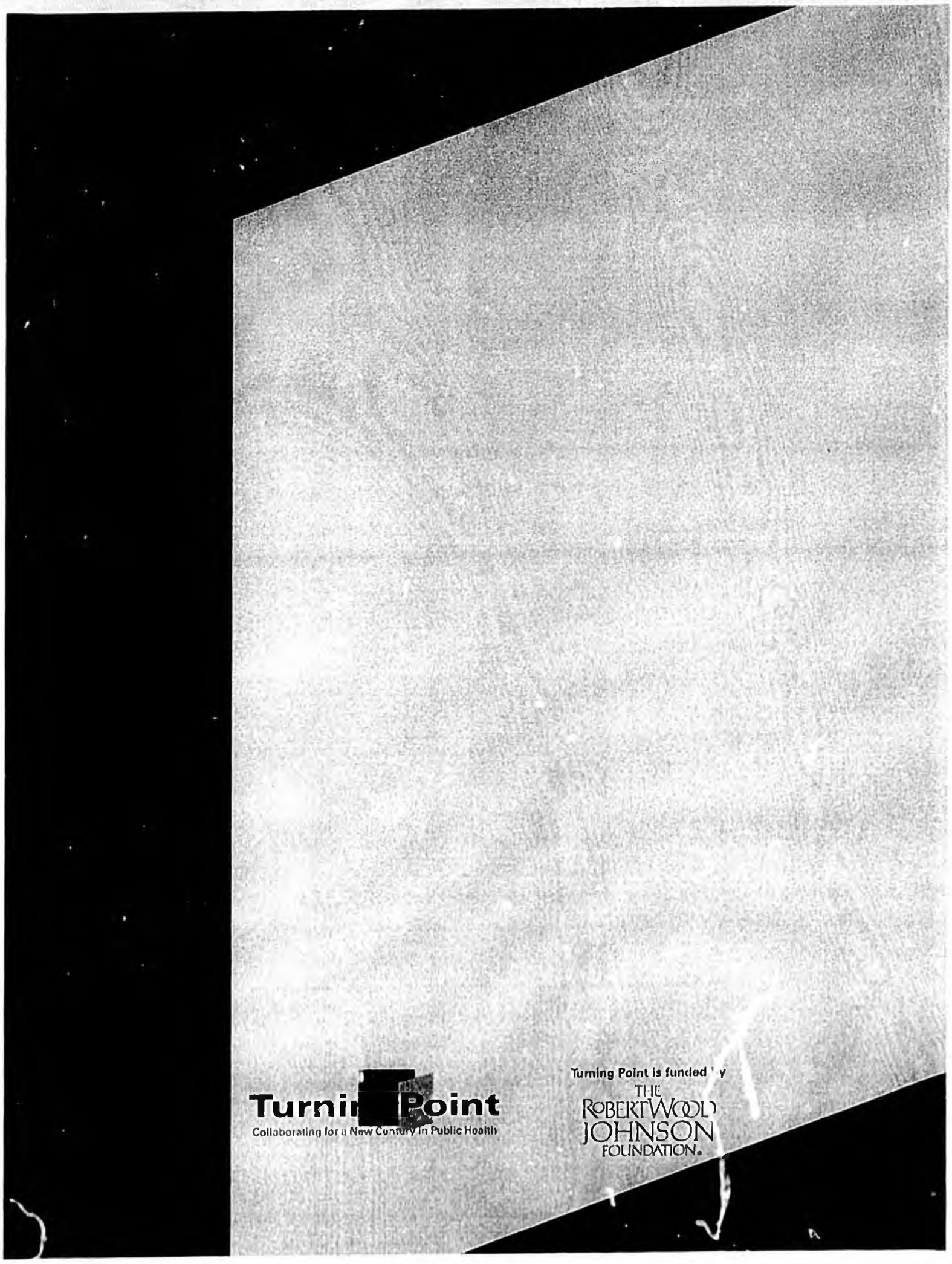
Turning Point
Collaborating for a New Century in Public Health
Turning Point is funded by
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JOHNSON
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States of Change

Stories of Transformation in Public Health

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Seattle, Washington
April 2004

Contents

The year 1996 ushered in a public health revolution. Melding their visions of health improvement and community empowerment, The Robert Wood Johnson Foundation and the W.K. Kellogg Foundation heeded the growing call for improved public health infrastructure. Dr. Susan Hassmiller of RWJF and Dr. Barbara Sabol of WKKF, together with Dr. Bobbie Berkowitz of the University of Washington and Dr. Vincent Lafronza of the National Association of County and City Health Officials, designed an initiative to build state and local public health capacity—capacity to ensure the conditions that keep people healthy, capacity to respond to emergencies, and capacity to eliminate health disparities. Turning Point embraced the concept of collaborative partnership between public health and non-public health entities to assess systems and create public health improvement plans. The ultimate vision of the initiative is a public health system responsive to the needs of its communities, devoting resources to areas that can best improve population health.

The Turning Point Initiative
Collaboration Brings Results

Was Turning Point really necessary? Absolutely! Over the past century, health status in the US declined sharply. Even with our technical advantage and our incredible medical research, population health is lagging, and health disparities are rampant. In the 1960s the US was ranked the 10th healthiest nation in the world. Now, in spite of spending nearly half of the world's health care budget, we are 26th. The promise of health insurance from the New Deal era has eroded and left us with millions of under-insured and uninsured men, women, and children. Type 2 diabetes, once called "adult onset" is now on the rise among the young, putting children at risk of a lifetime of chronic disease. Diet and physical activity patterns are now greater contributors to mortality than tobacco use and are increasing in impact. Preventable chronic disease costs our nation millions of dollars each year, yet public health continues to be underfunded. More than ever, prevention and health promotion efforts matter to individual health and the health of our nation.

A federally led taskforce had developed a vision of public health's role—the Ten Essential Services of Public Health, based on the Institute of Medicine's three core functions. The Institute of Medicine documented in black and white the decayed state of public health and prodded public health leaders to seek creative solutions to building infrastructure. Bobbie Berkowitz and Vincent Lafronza designed Turning Point to incorporate the best practices of public health. When nearly all 50 states applied for Turning Point grants and were willing to collaborate with those outside of traditional public health, it was apparent that a turning point was on the horizon. The initiative was developed at the right time.

When nearly all 50 states applied for Turning Point grants and were willing to collaborate with those outside of traditional public health, it was apparent that a turning point was on the horizon. The initiative was developed at the right time.

In 1998, 21 states and 41 communities hit the ground running. After two years of coalition building, assessment, and planning, they implemented various tactics for improving public health systems. From the foundations'

RWJF Turning Point National Program Office Staff (left to right): Anita Kamran, Bud Nicola, Betty Bekemeier, Fred Abrahamson, Jennifer Griffin, Bobbie Berkowitz, Judith Yarrow, Marleyse Borchard, and Stephen Padgett

big vision, very concrete state and local improvements have taken place and continue to emerge. Turning Point states have created workforce development innovations, built public health infrastructure, created tools to improve public health practice, developed mechanisms to eliminate health disparities, and leveraged resources for public health. All the while they have proven the value of the collaborative model through the relationships they have fostered between typically disparate entities, and through the achievements they've won together. The value of the collaborative model shone through when, in the spring of 2002, states organized to create plans for bioterrorism funding. Turning Point states already had working coalitions with community partners, emergency responders, and other nontraditional partners such as business. These collaborative partnerships placed Turning Point states ahead of the curve in being able to respond quickly to the need for preparedness plans for public health.

Bobbie Berkowitz's team at Turning Point's National Program Office promotes the achievements of the initiative through technical assistance to the states and their partnerships, dissemination of stories and outcomes, and ongoing communication to create a learning community among the states. The National Program Office mirrors the unique philosophy of the program, with team members working collaboratively to achieve the best results for the program and for public health.

Public health system change takes time, effort, and innovation. Building infrastructure does not immediately translate to improved health outcomes, but change is visible. Public health systems can be improved through collaborative partnerships building on the work of national partners. As recent years have shown us, public health is not alone in the business of improving citizens' health. Partnering with others is not only necessary but desirable. The foundations' investment in Turning Point has paid off exponentially. Public health is indeed a good buy.

With 3 million lakes and more than half a million square miles of pure nature, it's hard to envision Alaska as a place of thriving technology. But it is true. In fact, an economy built on development of Alaska's natural resources has allowed government and industry to invest and become one of the most technologically advanced states in the nation. So when the Alaska Turning Point Initiative was funded, public health stakeholders decided to take advantage of this technological leverage and create a public health information system.

Alaska Turning Point
North to the Future

The Turning Point Initiative started with a general idea that the various components of the public health system in Alaska—state, local, tribal, public sector, private sector, nonprofits—already collected and analyzed a lot of health status information. It seemed feasible to find a way to create a single electronic "door" through which much of it could be made readily available on the state Web site. Add some census demographics and clear instructions on how to interpret and use health statistics and the Public Health Information System would be in business.

It's not as easy as it sounds.

Creating the Public Health Information System probed some sensitive parts of the organizational culture... even questions about why it was necessary or beneficial to make data available to the public.

There were of course technical issues to sort out, design questions to settle, and access concerns to address. The biggest surprise, however, was how difficult it was simply to *obtain* the data. Creating the Public Health Information System probed some sensitive parts of the organizational culture: possessiveness by those who "owned" the various databases, concerns about the public misunderstanding or misinterpreting data, even questions about why it was necessary or beneficial to make data available to the public.

The initiative also had to plow through ways to promote an external focus on the public rather than an internal focus on the agency, and found obstacles when experimenting with approaches to data analysis and presentation. How could they present data on a small village without breaching privacy? These obstacles are expected in any project implementation, but add the additional challenges of a change in political leadership, significant budget cuts, department-wide reorganization, and a high rate of team member turnover, and the initiative's focus went from just implementing a plan to keeping the plan alive as players came and went.

But the initiative endured and what resulted was the long-awaited Alaska Public Health Information System, now live and available to the public on the World Wide Web. The system provides one-stop-shopping for health statistics and data and is available to the public. The Alaska Turning Point Initiative was able not only to pull buried data together in an efficient, categorical, user-friendly portal, but to complete the project amidst chaotic environmental changes.

At a Glance: *Alaska*

Aim of Alaska Turning Point

Alaska Turning Point has focused on developing a strong public health system to protect and improve the health of Alaskans. The two goals of this project are to: 1) provide information to policy makers, public health system partners, and the general public about the health status of Alaskans; and 2) provide community-based organizations with data and information, as well as the technical assistance on how to use it, in order to conduct community assessments and plan health improvement initiatives.

Alaska's Public Health Challenges

The effectiveness of Alaska's public health system is challenged by the emergence of new public health problems and environmental issues and by changes to health systems, health care financing, and government structures. Public health has a mission to protect and improve health. To carry out this mission effectively and use its resources wisely, the public health system needs up-to-date information about the diseases, conditions, and other health threats affecting population groups. Among the most significant and persistent public health concerns in Alaska today are tobacco use, alcohol consumption, injuries, suicide, nutrition, and chronic diseases. Inadequate access to health status statistics and information was identified in the Alaska Public Health Improvement process as a significant problem in Alaska's public health system.

Alaska Turning Point's Contribution to Improving Public Health

- Displaying public health information in a location accessible to all components of a complex public health system to assist with decision making at all levels
- Making reports, publications, and analyses developed by Turning Point available on the Internet to be used to assess health needs, establish priorities, and develop improvement strategies on a state, regional, or local level
- Identifying and setting goals to be reached among communities throughout Alaska using data to impact key health issues

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Bob Cassa serves his community by developing the conditions that will keep the population healthy. In his case, his community is a nation within a nation, the San Carlos Apache Nation in Arizona. A public health educator with the Indian Health Service, he coordinates, organizes, and implements a variety of health promotion and disease prevention activities in the schools and community. He especially loves working to improve the health of kids because he remembers what it was like to be young and making life-altering decisions. One of those decisions led him to public health and back to the San Carlos Apache Nation.

Arizona Turning Point
Collaborating for Community Health

Twenty-nine years ago, San Carlos tribal leaders saw the future of their nation in a promising kid and encouraged him to pursue higher education. When Bob first started at Arizona State University, his options were wide open, but he soon found himself in pursuit of a BA in Health Services. As a child, Bob recalls being a patient in the local hospital, where he remembers noticing the great number of non-native doctors and nurses. His decision to go into the health field came in part from his awareness of the need to increase the number of native providers. After receiving his bachelor's degree, he followed up with a Master's in Public Health from the University of Hawaii. He started his career with IHS in 1985 in Nevada but soon found his way back home to San Carlos in 1988.

The training sessions prompted Bob to identify how he could improve health education through better collaboration, communication, community assessment, and community participation.

Bob had already been serving in his community for 16 years when he was asked to participate in a training program called the Academy Without Walls. Created by Arizona Turning Point and the Mel and Enid Zuckerman Arizona College of Public Health, the Academy delivers training to frontline public health workers in Arizona. San Carlos was chosen as a pilot site for the Academy's competency based training in basic public health science skills, community dimensions of practice, and cultural competency. Tribal health department employees and the employees of the Indian Health Service Unit planned to participate in the Academy together to strengthen communication and collaboration between the two entities.

For Bob, the experience allowed him to revisit key principles in health education and the underlying purpose of public health. For others, some or all of the information was new. The training sessions prompted Bob to identify how he could improve health education through better collaboration, communication, community assessment, and community participation. Bob recognized that although he and his colleagues valued collaboration, sometimes in the daily activities of doing their jobs, the importance of collaboration was lost.

The Academy Without Walls provided public health workers who serve the people of San Carlos with tools, resources, ideas, and the opportunity to explore collaboration. Several agencies within San Carlos had been planning programs for kids during spring break. As a result of their participation in the Academy, some IHS departments and the tribal health programs collaborated with other community groups, such as the Boys and Girls Club, to put on a spring break event together. The larger event allowed them all to do more for the kids with the same resources. The spring break event and the lessons learned from the Academy Without Walls are living on in San Carlos. Agencies and community groups now collaborate in other ways to improve health and are moving in a new direction to achieve public health gains—together.

At a Glance: *Arizona*

Aim of Arizona Turning Point

Arizona Turning Point works to make the public health system more responsive to community concerns. Working collaboratively with communities and key partners, Turning Point addresses public health workforce development needs, consumer and public health information dissemination, disparities in health status, and public health advocacy.

Arizona's Public Health Challenges

Arizona's population has nearly doubled in the last 20 years, and yet the public health workforce has not kept pace. Arizona has only 48 public health workers for every 100,000 residents (nationally the rate is 158 public health workers for every 100,000 residents). Arizonans' life expectancy trails the national average by 5 years, and Arizona Native Americans' life expectancy falls short of the national average by more than 20 years. The leading causes of death are largely preventable through access to care, education, and changes in behavior.

Arizona Turning Point's Contribution to Improving Public Health

Arizona Turning Point has provided workforce development opportunities, increased access to information, and increased community capacity by:

- Designing and implementing the Arizona Academy Without Walls, a series of trainings intended to build capacity and competencies of the workforce so that they are better able to address the state's public health concerns. A pilot phase included the development, delivery, and evaluation of competency-based curricula in three areas: basic public health sciences, community dimensions of practice and cultural competency. Trainings were delivered to 326 participants through pilot training sites. The curricula has now been refined and will serve as the basis for ongoing continuing education through the Academy.
- Designing and implementing a Web-based resource to facilitate access to public health and consumer health information for public health professionals and the general public. AZHealthInfo.org is a continuously expanding Web site developed by Turning Point through an innovative partnership with the Arizona Health Sciences Library and other partners.
- Developing a series of training sessions in partnership with community groups, organizations, coalitions, local Turning Point initiatives, and leadership development programs. Trainings are being designed to augment the work the partners are already doing and will cover basic public health topics with the goal of enabling public health to come to the forefront of community issues.

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In the middle of a community health meeting in Colorado, one man spoke from the heart. The respected African American leader shared his story publicly. He talked about learning that he had high blood pressure as a young man and his ongoing fears of heart disease, which took the life of his father at a young age. He shared with his neighbors the sorrow of watching his beloved mother and older brother suffer from diabetes and eventually die, far before their time.

Colorado Turning Point

Health Disparities: Silent No Longer

The depth of his personal loss was recently measured when his sister succumbed to breast cancer. In the quiet room he and the others reflected on the toll disease was taking on their families. When he broke the silence and asked his neighbors and friends how many of them had been diagnosed with a chronic disease, the majority of people raised their hands. This symbolically stated what the state's Turning Point Initiative had recently begun tracking: African Americans were carrying more than their share of the burden of disease. Did it have to be that way?

Health disparities has been a silent problem for decades. Community members were aware that their friends and families were getting sick, but only anecdotes hinted at the extent of the problem. Although several programs within Colorado's Department of Public Health and Environment collect data on specific diseases, historically, no one was responsible for tracking racial and ethnicity health indicators collectively. That changed in 2001, when Colorado's Turning Point initiative synthesized the Health Department's data and, for the first time, reported on health status by race and ethnicity. The initiative's director, Jill Hunsaker, discovered from working with the data, what the community leader knew from life experience: in Colorado, African Americans died at a rate up to three times higher than Caucasians, and had an overall life expectancy that is four years less. This started the ball rolling.

The Turning Point partnership began working with communities of color to build awareness of health disparities. Together, they advocated for a more diverse public health workforce, a Citizen's Advisory Commission on Minority Health, and a new Office of Health Disparities at the Colorado Department of Public Health and Environment. These improvements are all now in the development stage.

In Colorado, solving the problem of health disparities could be tackled only when policy makers and public health entities became aware of its pervasiveness. And that story hadn't been told.

Colorado's challenges to improving health systems for diverse cultures are not unlike other states. In Colorado, solving the problem of health disparities could be tackled only when policy makers and public health entities became aware of its pervasiveness. And that story hadn't been told.

Agency resources fueled by the community's knowledge, wisdom, and advocacy seem to be a solid foundation for a future with reduced health disparities. In Colorado, the Department's first stab at tackling the health disparities problem was to document it. As people of color saw the charts and graphs, they exclaimed, "We sensed something all along but now we have proof."

At a Glance: *Colorado*

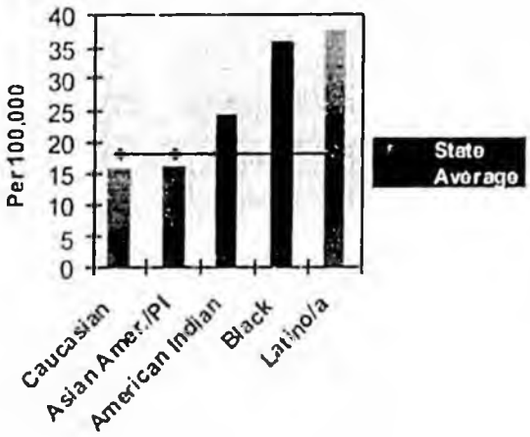
Aim of Colorado Turning Point

Colorado Turning Point works to ensure that all Coloradans have an equal opportunity to be healthy, regardless of race and ethnicity.

Colorado's Public Health Challenges

Colorado is one of the healthiest states in the country; however, not all demographic groups have equal health status. People of color experience poorer health outcomes in almost every area of health than do the rest of the state's population.

Diabetes Death Rates: Age-Adjusted
Colorado Annual Average 1998-2002



African Americans experience:

- The highest overall rates of death and shortest life expectancies
- The highest rates of death from cancer, stroke, AIDS, heart disease, and infant mortality

Latinos/as experience:

- The highest rates of death from diabetes
- The highest teen fertility (birth) rate
- The highest rates of death from unintentional injuries

American Indians experience:

- The highest rates of death from chronic liver disease
- The highest rates of death from motor vehicle accidents

Colorado Turning Point's Contribution to Improving Public Health

The Colorado Turning Point Initiative is creating systems that work toward the pursuit of health equity and the elimination of health disparities. Examples include:

- Developing a state Office of Health Disparities and a Citizen's Commission on Minority Health
- Developing a minority health surveillance system and publication of regular reports of health disparities data
- Diversifying the public health workforce through recruitment, scholarships, and training programs
- Improving language assistance for people with limited English proficiency
- Building a statewide communication network, including job listings
- Providing education about health disparities and their root causes through media outreach, conferences, and publications

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Although perhaps not as glamorous as an episode of the West Wing, *making effective public policy is critical and ultimately can bring tremendous rewards. In Illinois, determination and strategy are the name of the game. After all, how can you advance health without an agreed upon plan for action?*

Illinois Turning Point
Advancing Public Health in the Policy Arena

Turning Point in Illinois lives within the Illinois Public Health Futures Institute. Led by director Elissa Bassler and with a dynamite steering committee, the Institute built on planning efforts from Illinois Turning Point and drafted legislation for ongoing State Health Improvement Planning. The "SHIP Act" would legislate creation of a task force composed of the governor's office, state agencies, and private sector entities to complete the first Statewide Health Improvement Plan by January 1, 2005. Using National Performance Standards and evaluating Illinoisans' health against Healthy People 2010 goals, the task force's recommendations would be based on evidence and would ensure that looming threats and existing health issues are reflected in new initiatives.

The broad-based partnership responsible for conceiving and drafting the SHIP Act ensured that it was thorough and well prepared. SHIP found unanimous support from a variety of usually contentious groups. When the time came, it was unanimously passed by both chambers of the Illinois General Assembly.

The broad-based partnership responsible for conceiving and drafting the SHIP Act ensured that it was thorough and well prepared. SHIP found unanimous support from a variety of usually contentious groups. When the time came, it was unanimously passed by both chambers of the Illinois General Assembly.

All indications were that the widely supported bill would be enacted, but the Institute's determination was tested. Governor Rod Blagojevich vetoed the legislation, citing existing initiatives to develop interagency coordination on health and the potential costs involved in creating a task force and a health improvement plan, especially in light of a budget shortfall. For the Institute and the bill's supporters, this was a surprising setback. However, faith in the policy process led the partnership back to examining the Act and strategizing next steps. They were not ready to give up and live with the status quo.

Not to be undone by one defeat, the Institute is moving forward with a new strategy: it is working to implement SHIP by tying together and enhancing a number of existing initiatives. Recently, the bill again passed the Illinois House unanimously and the Institute and the Blagojevich Administration have developed new parameters for the bill which will ensure the Governor's signature once the bill makes its way through the General Assembly process. The partnership engaged new allies, raised the Institute's profile in the legislative arena and with the administration, and demonstrated the capacity of a collaborative effort to generate overwhelming legislative support for public health improvement activities.

Public health's future relies more and more in successful partnering, educating the public, and assisting our governmental representatives to protect the public's health through law. As Illinois demonstrates, health policy setbacks aren't the end of the road. They push us to learn to work within politics to improve health.

At a Glance: *Illinois*

Illinois Public Health Futures INSTITUTE

Aim of Illinois Turning Point

In Illinois, Turning Point is known as the Illinois Public Health Futures Institute (IPHFI). IPHFI is a partnership of public, private, and voluntary organizations. It works through partnerships to promote prevention and improve public health systems that maximize health and quality of life for the people of Illinois. Housed within the independent, nonprofit United Way of Illinois, IPHFI is in a position to provide not only training and resources to community-based groups, but also to represent the interests of public health on the policy level.

Illinois's Public Health Challenges

Illinois's ten leading causes of death resulted in more than 84,000 deaths in 2000. Many of those causes, including heart disease, cancer, accidents, diabetes, and liver disease are strongly associated with lifestyle and social factors. As many as half of those deaths could have been prevented. Illinois's efforts to improve health are fragmented among multiple state agencies and across the private and nonprofit sectors. Local partnerships vary greatly in their resources and capabilities.

What does IPHFI's Partnership Look Like?

IPHFI actively engages a variety of partners from a variety of sectors:

- Minority health groups
- Academia
- Rural health
- Hospitals
- Physicians' groups
- Social service
- State and local health departments

IPHFI's Contribution to Improving Public Health

IPHFI is implementing the following strategies to improve public health systems

- Engaging a broad range of public health interest groups to identify and address gaps and weaknesses in the public health system
- Mobilizing collective action to advocate at the policy level for improved public health policies and expanded resources for the unique needs of the people of Illinois
- Educating the public and policy makers on the complex, primary causes of poor health and strategies to address them
- Supporting the development of local community health partnerships through training, technical assistance, and policy development
- Assembling and disseminating data on the health of the public to promote understanding of Illinois's health status and system challenges and to support planning and policy development

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In 2000, Rosa Molina, director of the Medical Service Bureau, was helping minority Kansans access health services. At the same time, Kim Kimminau and the Kansas Turning Point partnership were collecting racial and ethnic minority data health statistics to identify the depth and seriousness of health disparities. It wasn't inevitable that Kim and Rosa would find each other; it was by design. Kim and her team knew that data improvement begins at the community level, with people rather than with numbers.

Kansas Turning Point
A Little Training Goes a Long Way

Early on, Turning Point approached several leaders of organizations providing health services to minority populations to join their partnership. By simply asking around, they learned of more individuals running innovative organizations to improve the health status of minorities in Kansas. Kim and her partners met with key people running these health access and health improvement programs. Kim wanted to learn firsthand from their perspectives on the nature and severity of the disparities their organizations confront daily.

Diverse groups came together, trained intensely for two days, and left with skills and an enormous sense of support....

At her first meeting with Rosa, Kim learned about the Medical Service Bureau's success in providing reduced cost access to health services for low-income, minority Kansans. While sharing perspectives on health disparities and discussing the workings of both of their organizations, they found a very concrete way Turning Point could be of assistance to Rosa's organization. Rosa was providing services, but the data she was collecting along the way was inadequate to help her support the need for her organization's existence.

Meeting with other directors and community, social, and public health workers, Turning Point partners heard the same need over and over. Data seemed distant and unapproachable for many experienced public health workers; they could not find the time and didn't have the skills to understand health statistics. Organizations served the community but didn't have the data to support their work. These frontline workers were frustrated that their successes and challenges were less convincing than they could have been with the "right" numbers.

In response, Kim and her team developed a comprehensive, two-day course to bring participants together to address the fear of data. Rosa and others at the training learned about data sources and accessing Internet-based information relevant to their clients, to their issues, and to their community. The results were staggering. Diverse groups came together, trained intensely, and left with skills and an enormous sense of support from Turning Point and their fellow public health workers. Rosa and her classmates have since shared how the training has changed their work. They are crafting better forms, surveys and patient-based data systems. Not only have they been using the information they learned, they have become agents of change. They have found the confidence to advocate for improved data collection of race, ethnicity, and primary language for their own programs and for the state.

At a Glance: *Kansas*

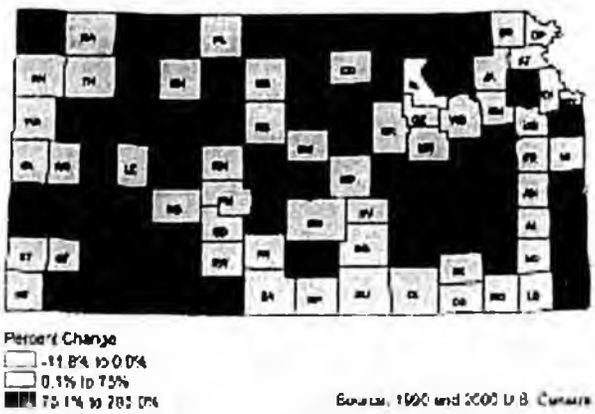
Aim of Kansas Turning Point

Kansas Turning Point aims to transform public health through partnerships, training, and informatics that focus on the delivery of essential services, with awareness of the growing diversity of Kansans. Their vision is public health system improvement leading to population health improvement in Kansas.

Kansas's Public Health Challenges

The leading causes of death disproportionately affect racial and ethnic minorities in Kansas. Understanding the effect of economics, access to health services, and geography, and having good data are key factors in improving Kansas citizens' health. Local public health departments provide important services and protections in the public's interest. In 105 counties, 99 local health departments serve the public, but the public health workforce is strained. In a rural state such as Kansas, ensuring that every available partner is engaged in the system is critical. Using data to make informed decisions in times of limited resources has never been more important.

Percent Change in Minority Population (1990-2000)



Source: 1990 and 2000 U.S. Census

Kansas Turning Point's Contribution to Improving Public Health

Following a highly inclusive public health improvement planning process, the Turning Point Partnership has:

- Synthesized health and health-related information on racial and ethnic minorities
- Convened a statewide conference to focus attention on the issue of health disparities
- Disseminated a software product that assists local public health departments' delivery of essential services
- Leveraged training opportunities to involve more individuals in the mission of public health
- Created a Certificate of Public Health program and a Public Health Scholars program
- Trained community leaders in public health, focusing on the use and interpretation of minority health data
- Encouraged the Health Care Data Governing Board to recommend standardization of race and ethnicity data collection
- Communicated to congressional delegates and to state legislators on the issues of public health, disparities, and workforce issues
- Developed a software model for a state data warehouse that will integrate local health department client and outcomes data

For More Information

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Terri Gremillion had her work cut out for her. Hired by the Heath Resource Services Administration's Better Health for the Delta program, Terri was a brand new "Community Encourager" for Avoyelles Parish, Louisiana. She had been entrusted with developing a rural health network to address health access issues for the parish residents. Avoyelles Parish is her home, and she knows the rural delta community well. The population of 41,481 suffers from a poverty rate of 25.9% and an unemployment rate of 8.3%. Avoyelles is a prime example of a challenged community in a very challenged state, recently ranked as the least healthy state in the US in terms of life expectancy and infant mortality.

Louisiana Turning Point
Encouraging the Encouragers

Terri quickly learned that being a "part time" Community Encourager takes more than 20 hours a week. The challenges of creating a network and addressing deep-rooted problems are huge. For Terri, "it was like being thrown into the deep end. We were several months behind...and I had nothing to go on." Her background in health care was helpful, but she didn't feel confident about the skills required in her new role. Terri was afraid that she might burn out in the face of these challenges, as others had before her.

Just as Terri was starting her work, the Center for Community Capacity, a program of Louisiana Turning Point and the Louisiana Public Health Institute, arranged to provide technical assistance to Community Encouragers. Terri enthusiastically attended trainings focused on leadership, strategic planning, coalition building, meeting facilitation, conflict resolution, advocacy, and lobbying. One training in particular, on collecting and assessing community data, gave her a perfect starting point for her work. Terry decided to conduct a needs assessment in Avoyelles Parish.

Something had to be done to alleviate the stress and anger of the residents if health and quality of life were really going to improve for the community.

Terri had never conducted a needs assessment before, but she knew she had to hear what community members felt their health priorities were. From her community of 41,000, Terri received 2,497 surveys. And a great surprise came out of the survey results—even though health care was important, stress and anger management were a greater concern to residents of Avoyelles Parish.

Community residents had never before expressed that stress and anger management were problems, but then again before Terri's survey, they didn't have a way to voice their concerns. Something had to be done to alleviate the stress and anger of the residents if health and quality of life were really going to improve for the community. Terri is now leading her network in developing strategic action plans to address stress and anger management, as well as other issues identified in her needs assessment.

Terri is busy but not burned out. With support and training, she has grown into her position as a Community Encourager. Terri has the satisfaction of trying to make the world a better place, starting right in her own community. Her success in Avoyelles Parish is a prime example of how, with a small investment from Better Health for the Delta and technical assistance from Turning Point's Center for Community Capacity, Louisiana communities can mobilize for health improvement.

At a Glance: *Louisiana*

Aim of Louisiana Turning Point

The Louisiana Turning Point Partnership is a statewide, multi-sector coalition dedicated to improving the quality and effectiveness of public health efforts in Louisiana and working to collectively transform our current health system into one that is more effective and responsive to the needs of our communities.

Louisiana's Public Health Challenges

Louisiana's public health system suffers from a lack of adequate funding and resources and a lack of effective cooperation among organizations that provide health care. For a decade, Louisiana has consistently ranked among the lowest 10 states for the health of its residents. Louisiana also has some of the highest levels in the US of unemployment, uninsured workers, and people with chronic diseases.

Louisiana Turning Point's Contribution to Improving Public Health

Louisiana has led a collaborative planning process, developed a dedicated coalition, and instituted dramatic system changes and innovations, including:

- The first comprehensive assessment of Louisiana's public health environment, culminating in the Louisiana Public Health Improvement Plan in June 2000
- Two programs were developed based on needs identified in the comprehensive assessment of the Louisiana public health environment:

  The Access to Care Congress, which convenes organizations engaged in improving the public's health in statewide forums that have allowed for comprehensive problem solving among local organizations to ensure access to care in the state

  The Center for Community Capacity, which helps communities gain the knowledge and skills necessary to successfully develop and sustain local health initiatives
- Training and technical support for 29 Delta Parishes on effective leadership, network development, and successful grant administration
- Strategic partnerships with other statewide organizations to coordinate public health efforts across the state and to increase collaboration and the efficiency of public health services

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On a recent winter day, Maine's State House hosted a bustling reception for the Maine Network of Healthy Communities (MNHC), a Turning Point-funded coalition of community groups who deliver an array of prevention and health promotion services throughout the state. As Governor John Baldacci noted in his remarks, it is members of the Network who "are out there doing what needs to be done" to help Maine people live healthier lives.

Maine Turning Point
Maine Communities Speak

In its three-year history, the coalition has taken important steps to realizing its vision of Maine people who "are healthy, not just because of access to appropriate medical services, but also because of neighborhood vitality, satisfying employment, safe environments, and diverse recreational, educational, and cultural opportunities."

Community coalitions have a rich history in Maine, a state without a structure of local health departments. Instead, organizational partnerships seek to address the conditions that have led to the state's epidemic of chronic disease. The Network stemmed from recognition that coalitions need a statewide voice to advocate for community health issues, as well as a mechanism to share information, ideas, and best practices.

The Network's origin stemmed from recognition that coalitions need a statewide voice to advocate for community health issues in Maine, as well as a mechanism to share information, ideas, and best practices.

"We've come along way since our inception," notes Network president Leah Binder. "Our first years were occupied with recruiting members and defining our vision and mission in a consensual way. It's important for local health activists to feel that they are heard."

In addition to organizational activities such as developing a board and membership requirements, coalition members were actively involved in the statewide Turning Point Project. In a variety of listening sessions, members made it clear that community voices should be heard in planning for public health infrastructure.

"One of our key activities has been mentoring and information sharing," notes Binder. She adds, "in a rural state like Maine, people can feel isolated. The Network helps us share ideas and support community health efforts across the state."

The coalition has created a Web site (www.thehcnetwork.org) and a newsletter to spread the word about member activities and programs. It recently began a Web-based "shareware" project, which will allow showcasing of "best practices" in community health efforts in Maine. The MNHC also has identified common Healthy Community indicators such as sector involvement, civic engagement, community change leadership, community change participation, scope of work, and resources generated.

In its final two years of funding, the Network plans to expand its mentoring focus, with an eye on sustainability. Public health activists recently noted that the value of Turning Point funding is that it has allowed them to be creative and resourceful — to build on their strengths and create capacity for the future. The Maine Network of Healthy Communities exemplifies how this creativity and capacity for innovation can be disseminated throughout the state.

At a Glance: *Maine*

MAINE

Turning Point

Aim of Maine Turning Point

Maine Turning Point is convened by the Maine Center for Public Health, a private, nonprofit organization established by the Maine State Legislature in 1996 to improve the health of Maine citizens. Maine Turning Point's mission is to develop a strong public health infrastructure that is able to respond to emerging challenges and has the capacity to improve the health status of Maine citizens.

Maine's Public Health Challenges

Heart disease is the leading cause of death, illness, and health care costs for citizens of Maine. Unlike almost all other states, Maine does not have a systematic, statewide public health structure at the local or regional level. Strong public health systems have the ability to improve the lives of the public, protect the public's health, and ensure the delivery of the essential public health services. Citizens of Maine should have access to the benefits of public health based in a strong system. Maine needs to build a public health infrastructure at the regional level that can complement the state system and local activities.

Maine Turning Point's Contribution to Improving Public Health

Maine Turning Point is:

- Promoting access and coordination of public health services throughout Maine communities to better protect the health of local citizens
- Convening community partnerships across the state to ensure the coordination of community-wide public health prevention and response programs
- Creating, through the Maine Network of Healthy Communities, new public health leaders at the local level using a formal mentoring program that matches experienced community health coalition leaders with emerging local leaders
- Providing and expanding education for public health professionals to ensure a skilled and competent workforce
- Working to improve the coordination between state-level authorities and local communities for public health data sharing, training opportunities, emergency response, and other emerging public health issues

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An eleven-year veteran of public health, Kristin was thinking of moving on. The assistant director of a rural county public health department in Minnesota, in the last few years she had grown tired of trying to find ways to do more with less. She was discouraged by the invisibility of public health in the community and, like many of her peers, was becoming overwhelmed by a growing mountain of new challenges. Rather than wanting to lead, Kristin was ready to check out.

Minnesota Turning Point
How Kristin Got Her Groove Back

Like Kristin, the entire field of public health is facing huge leadership challenges. Community needs are growing. Public health issues, such as emergency preparedness, are becoming more complex. Yet many leaders are retiring as the American workforce ages, and others have realized they neither can nor want to shoulder the burdens of leadership alone.

Late in 2002, Kristin's director encouraged her to apply for a new public health program focused on collaborative leadership. The Emerging Leaders Network (ELN) was developed in support of Minnesota's Turning Point Partnership vision: to strengthen the public health system. "We realized that we could use what we were learning through our involvement in the Turning Point Leadership Development National Excellence Collaborative to identify and mentor future leaders in our state," says Lee Kingsbury, Minnesota's Turning Point Program Coordinator. "We developed the Emerging Leaders Network to provide individuals with the training and confidence they need to step into formal and informal collaborative leadership roles."

For Kristin, participating in the yearlong ELN program was a turning point, both personally and professionally. "The most important moment for me came during a simulation of a public meeting," she says. "I had the opportunity to take on the role of an elected official, and when the situation got overwhelming, I checked out, letting a more assertive person take over. Later, as we all reflected on the experience, I discovered that others had wanted my leadership and that my way of leading would have calmed rather than escalated the situation. They valued my skills and my style in a way that I had not expected. From that realization, I gained a lot of confidence in my ability to lead and have become more willing to trust my instincts in difficult situations."

In another exercise, she was required to introduce herself to other attendees of a statewide conference. Together with an ELN "buddy" they strategized how to get acquainted with new colleagues. "I met many wonderful people that I would not have met otherwise," she says. "It helped me learn how to build a network and also made me appreciate all the different backgrounds, experiences, and perspectives of people in public health."

Kristin is looking ahead with renewed confidence. She has new passion for strengthening the public health system overall and she wants to share it. "These experiences," Kristin says, "forced me out of my comfort zone. By making new connections, meeting new individuals, and hearing different perspectives, I learned I am not alone. Because of the ELN experience I joined the Minnesota Public Health Association and accepted a place on the Governing Council. I never would have thought that possible a year ago! The ELN connected me to the entire public health system in a totally new way. I now know that together we *can* take on tomorrow's challenges."

At a Glance: *Minnesota*

Aim of Minnesota Turning Point

The Minnesota Turning Point partnership aims to improve the health of all residents by strengthening Minnesota's governmental public health system and expanding public health partnerships.

Minnesota's Public Health Challenges

Minnesota consistently ranks as one of the healthiest states in the US, due in large part to strong public health policies and partnerships. Broad averages, however, often mask significant differences in health status, and Minnesota has some of the widest gaps, of any state, in the health of various populations.

Minnesota Turning Point's Contribution to Improving Public Health

Minnesota Turning Point has achieved numerous system changes both within and outside of the traditional public health system through their expanded partnership. Outcomes include:

- A process to established minimum standards for local public health services and activities.
- Local planning requirements have been refocused on outcomes, local priorities and strategies.
- Civic engagement strategies have been incorporated throughout Minnesota Public Health.
- A major foundation and partner is redesigning funding guidelines to reflect the link between health status and social and economic conditions.
- "A Call to Action," a multi-disciplinary report, was written, focusing on social and economic change as a strategy for health improvement.
- Grants to local public health departments were consolidated, simplified, and new funding formulas were developed.
- Private and nonprofit sector partners worked together with public health to set statewide goals.
- A multi-disciplinary effort focused on social and economic change as a strategy for alleviating health disparities.
- An innovative program develops and supports emerging public health leaders.
- Redesign of public health reporting systems has begun.
- Work is underway to define what every Minnesotan should be able to expect from their local governmental public health agency.
- A workforce development project aims to increase the number and diversity of Minnesotans choosing careers in public health.

For More Information

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Melanie Glaus has thrived in the past 12 years as director of the Mississippi County Health Department in Missouri, in part because she is receptive to change. Her commitment to public health shows as she and her staff improve health for this agricultural community of 14,000. Melanie is walking the talk of meeting public health standards and getting ready to prove her department's excellence. Mississippi County has signed on to be one of the first health departments to go through Missouri's new Voluntary Accreditation program.

Missouri Turning Point
Nothing to Lose, Everything to Gain

Accreditation is a hot topic in public health. As a nation, we are debating the costs and benefits, logistics and feasibility of implementing a national accreditation program. Fear is a factor, as health departments wonder how accreditation will affect funding and staffing.

Although national accreditation is in debate, in 2000, the Missouri Turning Point partnership decided to move forward and create their own accreditation system to improve public health and ensure quality. The coalition of local and state public health, private entities, and academia knew that an independent party's stamp of quality and a sense of professional legitimacy would reap benefits for public health as they continue to work with diverse partners, the public, and political leaders. As they developed the system, they sought feedback along the way from every level of the health system. Most importantly, an independent 501(c)3, the Missouri Institute for Community Health (MICH), was created to administer accreditation. All along the way the process was kept 100% transparent to the public. As contentious issues arose, subcommittees were developed to come up with solutions. And they did. For example, academic partners and the state health department responded to concerns about making workforce credentials required by developing training programs so it is possible for the workforce to get the needed training. Resources such as distance-learning programs and short courses were developed alongside the standards.

The coalition...knew that an independent party's stamp of quality and a sense of professional legitimacy would reap benefits for public health as they continue to work with diverse partners, the public, and political leaders.

After pilot testing and refining, the system was ready to be rolled out. In September 2003, Melanie attended a meeting of Missouri local health departments, devoted entirely to reviewing the accreditation manual and answering questions about the process of applying for accreditation. Melanie was motivated to get her department accredited because the lack of formal accreditation had been an obstacle to arranging for nursing student rotations. Walking into the room, Melanie was confident that her department was performing the core functions of assessment, assurance, and policy development. She also knew that they were providing the Ten Essential Services to their community. Still, a tinge of fear remained as she wondered if requiring explicit qualifications for her nurses would make them even harder to hire. In rural areas nurses with bachelor's degrees are hard to find.

As she went through the day and discovered that the workforce requirements were reasonable and that training opportunities to help meet the standards were available, she relaxed. Over the course of the day Melanie could feel the tension seeping out of the room. Melanie and many of her colleagues came to the realization that accreditation would offer benefits, and that at this time, they had nothing to lose, and everything to gain. This voluntary accreditation system was of their own making and served their needs. Fear has been replaced by optimism as Missourians take ownership and responsibility for meeting the standards of public health.

At a Glance: *Missouri*

Missouri Institute for Community Health

Aim of MissouriTurning Point

In Missouri, theTurning Point Partnership created the Missouri Institute for Community Health (MICH), an independent 501(c)3 to facilitate planning and decision making among health care providers, the private sector, community colleges, universities, health and human service associations, and state and local government. MissouriTurning Point aims to improve the ability of its public health workforce to address priority health issues and be prepared for public health emergencies thereby improving the health and safety of all Missourians.

Missouri's Public Health Challenges

In recent years Missouri has fallen in the United Health Foundation's State Health Rankings from its place as the 26th healthiest state to the 32nd healthiest in overall key health indicators. Missourians are experiencing a significant increase in the number of deaths due to heart disease, cancer, and infectious disease. Combined with increases in smoking, children living in poverty, and a general lack of health insurance, the health of Missourians is in danger. A shortage of governmental resources has devastated the public health system and its capacity to respond to emerging threats.

Missouri's local public health departments vary in the level of service they provide and how closely they perform the core functions and essential services. Departments lacking accreditation from a designated neutral body sometimes experience a barrier to establishing credibility when working in coalitions with partners from accredited organizations.

MissouriTurning Point's Contribution to Improving Public Health

Missouri Institute for Community Health has:

- Developed and implemented a voluntary accreditation system for local public health departments. MICH promotes the benefits of voluntary accreditation: public recognition, enhancement of potential for increased local support and grant funding, a climate for ongoing self-study, and identification of areas of best practice or where improvement is needed.
- Encouraged and supported county-wide health assessment, planning, and prioritization of community health problems.
- Developed, with partners, ways to increase the skills and capacity of the public health workforce.
- Fostered the use of standards of practice in the performance of essential public health activities.

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Kathy Jensen is a farmer's wife and a public health nurse. At dawn, when her husband is already out tilling the fields, she drives 25 miles to open the doors of the only public health office in Sheridan County, population 4,000. Kathy—with some help from a WIC specialist, a roaming sanitarian, and a part-time nurse—embodies the entire county health staff. When an emergency hits, Kathy Jensen is the responder. When public health efforts are launched, she is the initiator. For Kathy, obtaining the skills and knowledge necessary to deal with the challenges of contemporary public health is vital to the health and safety of the community. But how can she get adequate training out in rural Sheridan County?

Montana Turning Point
Brick by Brick

Attending public health conferences and seminars in Helena means a 10-hour road trip or two commuter planes — and that's just to get there. While she's gone, the Sheridan County office closes. In the rural communities of Montana, the public health system is only as strong as its workers, and in Sheridan County, Kathy Jensen is the public health system.

When Montana first set out to improve its public health system in the mid-1990s, it was not with workforce training in mind; the focus was initially outward. Montana's public health reformers wanted policy makers and citizens to recognize the value and role of the public health system, in hopes of obtaining some funding. Through unsuccessful attempts to reach the public, a more immediate problem was discovered that demanded a more inward focus: consistent, high-quality training.

Through the support of the Turning Point Initiative, Montana established a Public Health Training Institute. The institute provides Internet-based and satellite training programs which are especially beneficial for rural communities that don't have university resources or public health colleges. The institute also developed a Summer Institute that, although sometimes held in Bozeman or Helena, provides unbeatable training and education in a few days versus traveling out-of-state several weeks a year.

Now, Kathy has options for enhancing her public health skills. Last June, she attended the Summer Institute for Public Health, where she learned new techniques in communicating the public health message and tracking communicable diseases. The county sanitarian participated in a public health practice module offered through distance learning and was able to network with other public health professionals without leaving town. County Health staff can enroll in computer courses designed specifically for public health professionals just a few miles from their homes. Today, training opportunities are marketed through the Institute's Web site and soon a new feature will allow Kathy and others to track their learning by using the Institute's new learning management system. The Institute's courses are continuing to evolve and are meeting the needs of Montana's public health workforce. "Almost everyday in this office, Turning Point has affected this community" says Kathy, "and will continue to impact our community forever. It's for real!"

In the rural communities of Montana, Kathy Jensens are everywhere. Increasing the capacity of the worker increases the capacity of the state's public health system, community by community.

In the rural communities of Montana, Kathy Jensens are everywhere. Increasing the capacity of the worker increases the capacity of the state's public health system, community by community. Together, they build a healthier Montana, brick by brick.

At a Glance: *Montana*

Aim of Montana Turning Point

Montana's Turning Point Initiative has defined the public health system to include traditional state and local public health agencies and a wide variety of community partners. These partners are engaged in implementing a strategic plan to improve Montana's public health system and the health of Montana residents.

Montana's Public Health Challenges

In 2000 Montana had one of the highest percentages of residents without health care coverage and had the lowest average annual pay of any state in the country. At the same time, obesity is on the rise, bringing increases in diabetes, heart disease, disabilities, and rising health care costs throughout the state. Montanans do not have access to a consistent set of public health services across the state. Fifty percent of Montana's local health departments reported they were meeting half or fewer of their communities needs related to the ten essential public health services.

Montana Turning Point's Contribution to Improving Public Health

The Montana Turning Point Partnership developed a strategic plan that guides its work. Accomplishments and areas of major focus include:

- Establishing the Bureau of Public Health System Improvement (assessment, health planning, training, preparedness, and informatics) to provide a focal point for public health system improvement and coordination, and to be a resource on public health system issues
- Implementing the Montana Public Health Training Institute, which is a career-long learning center for public health workers
- Enhancing communication and coordination among statewide and local public health programs
- Ensuring that public health emergency preparedness activities are consistent and coordinated with the Strategic Plan for Public Health System Improvement
- Coordinating health planning efforts such as county health profiles and the Montana Health Agenda
- Reviewing Montana's public health statutes with the Turning Point Model Statute and the Model Emergency Powers Act
- Completing a state assessment using the CDC National Public Health Performance Standards

For More Information

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How do you advance health when your public health system lacks basic local services? Back in 1988, the Institute of Medicine proclaimed that public health was in disarray. They could have pointed to Nebraska as a prime example. In 2000 only 22 of the state's 93 counties were served by local public health departments. Perhaps worse, fewer than one-quarter of these departments assessed citizen's health status, developed policy around health issues, or ensured care of the citizenry.

Nebraska Turning Point
Now and Then

David Palm and Mary Munter of the State Department of Health decided to be proactive in creating change. Beginning with a broad-based partnership, including the Nebraska Public Health Association and all its key partners, they developed a comprehensive, written public health improvement plan. As anyone who has been in Nebraska during a football game knows, when Nebraskans want something, the entire state gets behind the effort. This time the goal was to gain lasting support for public health. A new era was about to begin.

The written plan and broad support gave the State Department of Health credibility with policy makers. When the legislature passed the Nebraska Health Care Funding Act in May 2001, it provided an annual appropriation of $5.7 million from the Tobacco Settlement Fund to build public health infrastructure across the state. Here was their golden opportunity, and they were ready for it. In the words of Dave Palm, "You have to be prepared to take advantage of opportunities when they arise. We were lucky to have the tobacco settlement money, but we only gained access to it because of a terrific coalition and a solid plan. When the legislature asked if we had a plan, we didn't just say yes; we showed it to them."

"When the legislature asked if we had a plan, we didn't just say yes; we showed it to them."

The legislation promoted formation of multi-county health departments and required each to provide the Ten Essential Services. Turning Point worked with communities and partnerships to translate the law into bricks and mortar, health directors, and skilled staff. Dave and Mary supported the effort, driving in the heat of summer and bitter cold of winter to each county to help build bridges. By June 2002, local health departments provided public health coverage for all but one of the 93 counties in the state; by 2004 all were included.

In 2004, Nebraska public health looks much different than in 2001. All communities are actively engaged in improving the health of their citizens. Local health departments have identified and tracked disease outbreaks, such as West Nile virus. They have partnered with local emergency management coalitions to develop plans for a bioterrorism event or a natural disaster. Health departments are battling obesity and chronic disease with a variety of health promotion and disease prevention programs to change health behaviors.

In 2003, staff from the health departments called upon their recently developed smallpox vaccination plans and implemented the pre-event smallpox vaccination initiative. Public health workers surprised even themselves when they discovered that they had mobilized to vaccinate more people for smallpox than any other state during the initial stages of the campaign.

Nebraska now has a public health system that is on its way to being among the most responsive public health systems in the country. As the changed system proves itself, public health grows in importance to Nebraskans. Nebraska's success shows us that it is never too late to start mobilizing for change.

At a Glance: *Nebraska*

Aim of Nebraska Turning Point

Nebraska Turning Point's goal is to build the local public health infrastructure so that all people in Nebraska are covered by a local health department.

Nebraska's Public Health Challenges

Obesity is on the rise in Nebraska. Nebraska high school students are twice as likely to drink and drive as their counterparts nationwide. Many Nebraskans are uninsured or under-insured, limiting their access to timely preventive and medical services. Major differences exist between the health of Nebraska's general population and its racial/ethnic minority populations. In 2000, Nebraska had limited organizational capacity, limited staff, and no dedicated state funds for local public health. Only 16 local health departments covered 22 of the state's 93 counties.

Nebraska Local Health Districts prior to 2000

Nebraska Turning Point's Contribution to Improving Public Health

- The Turning Point Project allowed a broad and diverse coalition to set the future direction for public health in the state.
- New legislation was passed in 2001 that used Tobacco Settlement Funds to fund 16 new multi-county local public health departments.
- The local public health departments must consist of at least three contiguous counties and have 30,000 people.
- Annual funding levels range from $160,000 to more than $800,000.
- Key accomplishments include: comprehensive needs assessments, implementation of many health promotion programs, organized surveillance programs, and local bioterrorism and emergency preparedness plans.

Nebraska Local Health Districts 2002

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In Nevada, getting the "prevention" message out to the public is tough. The layout of the land—miles of sparse desert scattered with small communities—complicates advertisement of health promotion campaigns. Citizens seldom seek out education on disease prevention and improving community health. Nevada's suicide rate ranks fourth in the nation, and the state stands high in its rate of alcohol- and tobacco-related illnesses. Nevada has yet to ban smoking in daycare centers and grocery stores. It's safe to assume prevention isn't getting its fair share of water-cooler talk.

Nevada Turning Point
Is Anybody Out There?

Nevada has two full-service local health departments, in urban Clark and Washoe counties, and a third developing in Carson City. Clark County Health District, located in the nation's fastest growing county, serves 1.5 million residents in the area surrounding Las Vegas. Washoe County Health Department's jurisdiction extends 6,600 square miles from Lake Tahoe to the Idaho border. Carson City, located 33 miles west of Reno, recently appointed a County Board of Health and is expanding its range of public health services. Nevada State Health Division provides public health services throughout the remaining 95,884 square miles of the state. Local and state health officers who participated in Turning Point's formative stages asked Nevada Public Health Foundation to help get the prevention message out and to build a statewide constituency to support public health.

To build a statewide constituency, Nevada Turning Point sought to put the public in public heath—getting information out to Nevada's citizenry, but also getting information back about how they think public health can improve their lives.

To build a statewide constituency, Nevada Turning Point sought to put the public in public health--getting information out to Nevada's citizenry, but also getting information back about how they think public health can improve their lives. The challenge was reaching the public in a comprehensive way. Technology answered the need. However, the Foundation lacked the funds to create an electronic communication system. With direction and funding from the Turning Point Initiative, the Foundation developed a system, and the Citizens' Public Health Network was born.

The new program works as a high-powered database that categorizes and quickly sorts contacts by groups and regions, allowing the Foundation to disseminate information quickly and efficiently. It allows for bulk e-mailing and provides Internet capabilities the Foundation didn't previously have. Using the Network, the Foundation now has a technological connection with public health officials, federal and state legislators, schools, community organizations, faith communities, and other community members who can both use the information and distribute it to their own constituencies.

The Network provides Nevada communities with public health contacts and resources they can reach with a click of the mouse or a dial of the phone. Public health agencies and community-based organizations can, if they choose, use the Network as a conduit for informing people of the state, a particular region, or an interest group about prevention strategies, public health events, training opportunities, or public health policy issues.

The Citizens' Public Health Network gives Nevada a broadcast medium to get the prevention message beyond the public health community to the public itself and to hear what the public has to say in return.

At a Glance: *Nevada*

NEVADA PUBLIC HEALTH FOUNDATION

Aim of Nevada Turning Point

Nevada Turning Point's goal is an improved public health system that promotes health and prevents disease. Nevada Turning Point listens to, educates, and mobilizes Nevadans to improve the health of their communities and strengthen the public health system so it can respond to emerging public health challenges.

Nevada's Public Health Challenges

Nevada's smoking rates and health problems from tobacco are among the highest in the nation. Yet Nevada is one of the few states that does not allow local governments to regulate tobacco. Nevada has the highest proportion of suicides in the nation, double the national rate. Nevadans report poorer health than the rest of the nation and engage in more risk behaviors that contribute to poor health. Despite these facts and a dramatic increase in population in the past decade (over a 66% increase over ten years), there has not been an increase in state spending for health promotion and disease prevention since 1992. Only two of Nevada's seventeen counties have a local health department, and the lack of any school of public health translates to fewer educational opportunities for new and existing public health workers.

Nevada Turning Point's Contribution to Improving Public Health

Nevada Turning Point has:

- Developed a Citizens' Public Health Network to establish connections among Nevadans and their organizations to increase collaboration and success in achieving community improvements
- Joined with the Utah Department of Health to create the Great Basin Public Health Leadership Institute
- Improved policy and programming related to tobacco use and suicide prevention
- Collaborated with communities to develop local public health systems in Nevada's rural communities
- Offered community education on public health issues and the political process
- Educated elected officials and government managers about public health issues

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At 8:30 pm on a typical winter eve in February 2004, Donna Tighe received an unexpected phone call at her home. Dr. Jesse Greenblatt, the New Hampshire state epidemiologist, was calling to inform her that the State Health Department had a confirmed report of a hepatitis A case involving a fast-food worker from her area. After consulting throughout the day with the CDC and the national restaurant chain, the department determined that it would be necessary to immunize approximately 2,000 people over the course of the next few days. As the director of the Greater Derry Health and Safety Coalition, Donna would need to mobilize her public health coalition to help make it happen.

New Hampshire Turning Point
Roll Up Your Sleeves and Get It Done

The central activity of the New Hampshire Turning Point Initiative has been a community grant program to stimulate expansion of the local public health infrastructure. The Greater Derry Health and Safety Council is one of four initial grantees competitively selected to demonstrate new models for delivering local public health services. Key ingredients for improving the public health infrastructure have included increasing coordination between state agencies, formalizing the traditional role of non-governmental organizations in providing a range of public health services, and strengthening the capacity of local government to partner more fully with non-governmental organizations and the state. The contemporary context of bioterrorism and related resources has also served to focus attention and build new partnerships for public health. But on a Thursday evening in February 2004, the threat that faced one New Hampshire community came not from terrorists, but from tacos.

As a result of previous planning and relationship building, necessary decisions were quickly made about such things as clinic sites, staffing, equipment, supplies, public information, and media relations.

As events unfolded over the next few days, however, it was clear that the work of the past 30 months was paying off. "We are like a cable," said Donna. "We connect the people who need to be connected to make things happen." As a result of previous planning and relationship building, necessary decisions were quickly made about such things as clinic sites, staffing, equipment, supplies, public information, and media relations. "In the past, we would have spent the first hour or two just introducing ourselves," Derry Fire Chief and Emergency Management Director George Klauber said.

By the following Tuesday, through a series of clinics, more than 2,500 area residents had received an injection of immune globulin, an

antibody treatment that greatly lessens the chances of acquiring hepatitis A. The response was a true collaboration involving a variety of state and local public health and emergency management partners. And it was enough to convince MaryAnn Cooney, director of the State Office of Community and Public Health, of the need for more local public health network sites. "Derry was all over it. They mobilized, but there are communities in the state that don't have that yet," she said. Dr. Ed Thompson, Deputy Director for Public Health Services at the CDC, also noticed the collaborative response. As quoted by an Associated Press reporter covering the incident, Dr. Thompson said, "There's a great roll-up-your-sleeves-and-get-it-done attitude that we saw there."

At a Glance: *New Hampshire*

Aim of New Hampshire Turning Point

The central activity of the Turning Point partnership in New Hampshire has been development of the New Hampshire Public Health Network, a system of regional community collaboratives working to create a more effective and responsive local public health system.

New Hampshire's Public Health Challenges

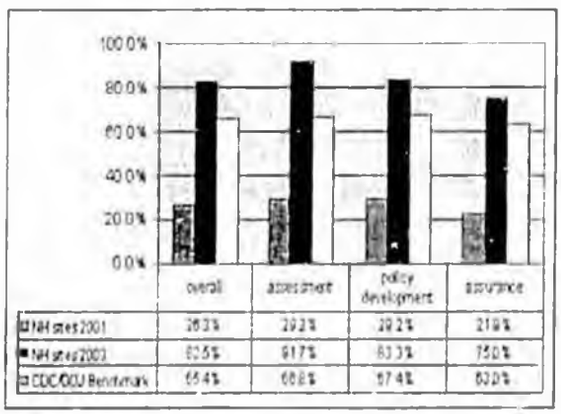
New Hampshire ranks among the healthiest states in the US when measured by child health, and health care access and quality. But disparities exist in the health and quality of life of many residents. New Hampshire has a fragmented local public health system. The 234 appointed health officers, often with limited training in health, represent local governmental public health in most towns. By default, police, fire, school nurses, and nonprofit health and human service providers fulfill roles that are more typically assigned to trained local public health officials. There is a lack of cohesive disease control and surveillance, a limited capacity to identify and maximize statewide assets related to public health, and a shortage of public health resources coming into the state.

New Hampshire Turning Point's Contribution to Improving Public Health

The major development from New Hampshire Turning Point is the Network itself, which through its regional collaboratives, now maximizes resources to improve the health of more than 60% of New Hampshire residents.

- The Network collaboratives work together with state partners to provide the Ten Essential Services of Public Health and unique models tailored to individual regional needs and assets.
- The four original Network collaboratives used the Local Public Health System Performance Surveillance and Assessment Tool (20 Questions), a precursor of the National Public Health Performance Standards, to assess local needs and identify system gaps.
- Local public health capacity was measured at baseline (2001) before Network collaboratives implemented any efforts to increase capacity, then again after each implemented strategies for public health improvement (2003). Significant capacity improvements occurred over the two years, with the mean overall capacity score increasing from a pre-Network score of 26% to 82%.

Local Public Health Capacity
Assessment of Core Function-Related Capacity



- The Network has successfully leveraged upwards of $4 million to support public health in New Hampshire.

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Turning Point believes that public health partnerships can create solutions to difficult public health problems. Solutions that are elusive to individual organizations working alone suddenly are in reach when organizations recognize common goals and pool their financial and technical resources.

New York Turning Point
Local Solutions Used Nationally

Back in 1998, two now retired local public health officials from different New York counties were frustrated with the lack of appropriate training opportunities for their staff. Dyan Campbell and Jack Andrus called a meeting with New York State Association of County Health Officials director, Jo Ann Bennison, and the dean and the director of Continuing Education at the State University at Albany's School of Public Health.

Dyan and Jack shared the problems they encountered providing continuing education for their staffs — cost, staff time taken away from work, and the difficulty of traveling to far-away trainings. While recognizing that resources system-wide were slim, they still hoped for a solution.

Faced with a concrete request for help, Jo Ann Bennison and her team brought in other partners, among them, the State Department of Health and the Turning Point Initiative. After considering different options, they settled upon creating a monthly satellite broadcast because they knew every county had access to satellite equipment, even if only through sister agencies. Before long the Third Thursday Breakfast Broadcast Series (T2B2) was born—a free, continuing education opportunity, requiring only one hour a month and virtually no travel time or trouble for public health workers.

Since its start in May 1999, T2B2 has delivered upwards of 60 broadcasts on such topics as "Emergency Preparedness: What is Your Competency?", "West Nile Virus: What Have We Learned Since 1999?" and the runaway hit "A Bug's Life: Basic Epidemiology." Reaching anywhere from 300 to 800 public health professionals at each live broadcast, the show's interview format leaves time for the guest expert to field questions submitted by participants by fax, e-mail, or phone. T2B2 has taken on a life of its own as people from outside New York have learned of it through listservs and from organizations such as the Public Health Foundation.

Begun with a great deal of creativity, seed money from Turning Point, and a tenuous shoestring budget, T2B2 has now found its stride. With stable funding and continued program direction from the partners, T2B2 conscientiously responds to the changing needs of New York public health professionals. Recently they were able to begin awarding CEU credits to participating professionals.

Perhaps the greatest benefit of T2B2 is summed up in the words of Jan Chytilo, director of Health Education in Broome County, NY, and site coordinator of T2B2 in her county. "Before T2B2 we had virtually nothing. Now, I sit at my desk and look across at the bookshelf of taped episodes of T2B2. We lend them to our partners and watch episodes during our 'Learning Lunches.' Public health can be so silo-driven, T2B2 helps us gain both technical skills and also a broader picture of what is being done in public health." Though viewers might not know the origins of T2B2, they have Dyan and Jack to thank, as well as a partnership that was, indeed, greater than the sum of its parts

At a Glance: *New York*

Aim of New York Turning Point

New York Turning Point has focused their efforts on building public health capacity through sustained training opportunities for a strong public health workforce.

New York's Public Health Challenges

New York State faces capacity challenges in the areas of recruitment, retention, and training of the public health workforce. In addition, the state has challenging workforce demographics, as well as ethnic, economic, cultural, and geographic diversity in the general population of the state which they serve. A recent survey found:

- NYSDOH has approximately 5,350 employees; New York LHDs have approximately 7,270 full-time equivalent public health workers.
- Difficulties recruiting qualified candidates for public health nurse, sanitarian, and health educator positions (especially in rural areas).
- Good retention but future losses due to aging workforce retirement.
- Substantial need for continuing education.
- Emerging public health issues is an area of great need.
- Access to training constrained by limited resources, inaccessible times and locations, competing priorities, and poorly designed training.

New York Turning Point's Contribution to Improving Public Health

Through development of a partnership between health departments, academic institutions, professional organizations, and others, New York Turning Point has developed and delivered coordinated training to state and local public health workers across the state. In addition, it has been successful in identifying and addressing long-term system changes necessary to strengthen the public health system. Initiatives include

- Third Thursday Breakfast Broadcasts (T2B2)
  - Established in 1999, this innovative monthly broadcast airs to local public health and community coalitions as well as across the nation by satellite.
  - Broadcasts are also available by Web-archived streaming video and through a video lending library.
- Public Health skills development courses and curriculum
  - Public Health 101 course
  - Basic Environmental Health course (8 modules over 14 days, mandated by Sanitary Code)
  - Annual New Local Public Health Director/Commissioner Orientation
  - Public Health Nursing Continuing Education (online course, 4 modules, CEUs)
  - Confidentiality Training (2-hour course)
  - Online Cross-Cultural Communication Training (in development)
  - SARS for Hospitals (3 Modules)
- Establishment of statewide public health training task force

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No single set of steps will bring about a better public health system. The mystery and beauty behind change, however, is that it can originate just about anywhere. And when the opportunity for change comes knocking, luck favors the prepared mind.

North Carolina Turning Point
Working Policy Magic

By 2003, the North CarolinaTurning Point partnership had considered a number of remedies to reverse the steady decline in the state's public health infrastructure. A team of talented and experienced professionals had assessed critical needs and created a strategic plan. To strengthen public health infrastructure, however, they needed one more crucial ingredient—a legislative champion.

From a completely unexpected quarter, they found not one champion, but three. Each year teams of working professionals gather at the University of North Carolina School of Public Health for the learning experience of a lifetime. The Public Health Leadership Program of 2002 included an unlikely team: State Senator Fletcher Hartsell, Linda Attarian, a graduate of UNC School of Public Health and an attorney to the North Carolina Speaker of the House, and John Shaw, former North Carolina local health director and 20-year veteran of public health.

Senator Hartsell, Linda, and John were interested in addressing public health's chronic infrastructure needs. For their class project, the team decided to draft legislation to strengthen public health infrastructure and, hopefully, improve the health status of North Carolinians. The director of North Carolina's Turning Point, Christopher Cooke, had sent Linda a preliminary draft of the Turning Point Model Public Health Act along with the recommendations from the North Carolina Public Health Improvement Plan. The tools were ready and waiting to be used. With these resources and a looming deadline, our three champions developed a draft statute to address the rapidly developing needs of North Carolina's public health system.

What started as a class project turned into the introduction of highly innovative legislation.

What started as a class project turned into the introduction of highly innovative legislation. Taking their "out of the box" thinking from the classroom to the real world, Senator Hartsell introduced Senate Bill 672, "A Bill to Strengthen the Public Health Infrastructure," to the North Carolina General Assembly in April 2003.

We learn our greatest lessons from our best attempts that fail. The bill spoke to real needs such as accreditation of public health agencies and integrated planning. Unfortunately, it did not pass both chambers. Policy makers and public health needed to learn to work together to build a better system, taking time to gather comments and build broad support. Senator Hartsell and his team's innovative efforts were not wasted, however. The immediate outcome of the introduction of Senate Bill 672 was that it brought policy makers and public health to the table around the need to strengthen the state's public health system.

Senator Hartsell, Linda Attarian, and John Shaw graduated from the Public Health Leadership Program in 2003. In response to their work, the North Carolina Public Health Task Force 2004 was initiated by the North Carolina Secretary of Health and Human Services. Crafting recommendations and redrafting the bill to reintroduce to the General Assembly in May 2004 is only part of their work. Perfecting the dance of public health and policy is the other part.

At a Glance: *North Carolina*

Aim of North Carolina Turning Point

North Carolina Turning Point aims to expand and enhance existing state and local partnerships working to meet North Carolinians' health needs. Turning Point contributes to public health improvement through its support of Healthy Carolinians, North Carolina's network of locally based, public-private partnerships to improve and protect the public's health.

North Carolina's Public Health Challenges

North Carolina ranks among the country's bottom third in overall health of its residents. Chronic diseases, which are largely preventable, consume 75% of North Carolina's health care dollars. Tobacco use alone costs North Carolinians $4.8 billion annually in both direct and indirect dollars. At the same time less than 1% a year of the state's total health care dollars goes to support health promotion and disease prevention.

North Carolina Turning Point's Contribution to Improving Public Health

North Carolina Turning Point and Healthy Carolinians have improved public health through policy and planning, preparedness and response assistance, workforce development and training innovations, institutionalization of health improvement, and strategic communication and marketing. Examples include:

- Provided information that contributed to the development of NC Senate Bill 672, a bill to strengthen public health infrastructure
- Guided the development of North Carolina's 2010 State Health Objectives (Healthy Carolinians)
- Integrated community-based partnerships, community assessment, and public health planning for North Carolina's public health system (Healthy Carolinians)
- Provided staff to the North Carolina Public Health Task Force 2004 to develop recommendations for strengthening public health infrastructure in North Carolina
- Assisted with the development of North Carolina's network of Public Health Regional Surveillance Teams
- Developed a Web-based course in Public Health Marketing for the Leadership Program at the UNC-CH School of Public Health
- Established the Social Marketing Matrix Team within the Division of Public Health to advance the use of social marketing in public health programs
- Helped to establish Healthy Carolinians, Inc., a not-for-profit arm of Healthy Carolinians, to leverage private sector support for the NC 2010 Health Objectives
- Contracted for the development of a marketing campaign for North Carolina's public health system using data from a statewide survey

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The US Department of Transportation estimates that the typical driver will experience a near collision two to three times a month and will be in some type of accident, on average, every six years. For one resident of Altus, Oklahoma, his six years came up. Twenty-year-old Jim Bob Redelsperger lost his life to a driver who failed to stop at a stop sign. He wasn't wearing a seat belt.

Oklahoma Turning Point
Saving Lives in Oklahoma

In Altus, there is no seatbelt law. For three years, the Altus City Council had voted down the ordinance that would require the citizens to buckle up or pay up. The Jackson County Turning Point partnership in Oklahoma decided to bring the matter to the council again, this time armed with the voices of the community in hopes the plight would be better received.

On February 10th, 2003, 13 members of the Turning Point partnership brought the seatbelt issue to the Altus City Council meeting. Six council members listened as Henry Hartsell, chairman of the partnership, reported the increasing traumatic brain injury rate, lost revenue due to low compliance, and shared survey results that declared lack of seatbelt use as one of the riskiest behaviors in the community. Brandie O'Conner, Turning Point representative, spoke about how adopting this simple habit could increase the community's health and safety. Dr. Randy Sheets, a former ER Medical Examiner and member of the partnership, has seen too many kids in his ER from not buckling up. He told the council members, "Kids think they are invincible, and something as simple as a ticket will get them wearing their seatbelt." But nothing seemed to be working. Pencils were tapping, mouths were yawning—the council had heard it all before. Several council members believed that wearing a seat belt was a choice, an issue of personal freedom, and they weren't interested in giving up any freedoms tonight.

As things were looking grim, a final member stood to speak. John Redelsperger, Jim Bob's father and a friend of Dr. Sheets, was a respected member of the community. Shortly before the city council meeting, Dr. Sheets had spoken to John about attending the meeting and telling his personal story advocating seatbelt use. John spoke of his 20-year-old son who also once enjoyed personal freedom. He wasn't wearing his seatbelt when he collided with the car that ran the stop sign and was killed instantly. John told the council that by not wearing his seatbelt, his son "paid the highest price." The other driver walked away from the accident. She *was* wearing her seatbelt.

On February 18, 2003, the Altus City seat belt ordinance was approved and one month later was officially in effect. Five of the six council members said that after they heard John Redelsperger's story, they changed their minds. His story convinced them to rethink their definition of personal freedom. The Turning Point partnership was successful in their efforts to bring not only community partnerships together, but also community members that are affected by health and safety laws daily. Since the ordinance passed, the rate of motor vehicle fatalities in Jackson County has decreased by 80%, and the personal injury rate has decreased by 15%.

At a Glance: *Oklahoma*

Aim of Oklahoma Turning Point

Oklahoma Turning Point is working to strengthen Oklahoma's public health infrastructure through community-based action in order to respond to the challenge of protecting and improving the public's health in the twenty-first century.

Oklahoma's Public Health Challenges

With health departments in 69 of its 77 counties, Oklahoma has one of the best public health infrastructures in the nation. Unfortunately, Oklahoma's public health infrastructure has not resulted in a healthier population. Oklahoma ranks 45th in the United Health Foundation 2003 State Health Rankings. Oklahoma ranks among the worst in infectious diseases, death rates, and teenage births. Oklahoma's death rate for heart disease is 21.43%, for cancer 3.33%, for injuries 28.73%, for stroke 14.75%, and for COPD 25.26% higher than the national average. Oklahoma citizens are overburdened with more than their share of disability and unnecessary death. An essential element missing in how public health deals with these problems in Oklahoma is community-based decision making.

Oklahoma Turning Point's Contribution to Improving Public Health

Turning Point is using innovative means to craft an improved public health system by:

- Using a community-based approach in public health decision making.
- Developing more than 48 local partnerships and working with state partners.
- Increasing cooperation of key state and local partners working toward healthy communities.
- Developing a network of local and state partners to address health-related smoke legislation. Several bills have been passed.
- Developing partnerships with state, county agencies, and communities to assess local public health needs and develop local solutions.
- Working with local partnerships to develop and implement Community Health Improvement Plans.
- Developing resources that will help communities implement population-wide services at the local level, including data access, Internet-based video conferencing, and e-mail policy alerts.

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Oregon's Turning Point Initiative began in 1998 with development of a broad-based partnership, an analysis of the public health system, and development of a public health improvement plan to lead Oregon toward a brighter public health future. Among the many priorities the partnership identified in the plan, two stood out. First, was to review Oregon's public health laws for their ability to protect the population against health threats, an activity that had not been done in 30 years. Increased threats of infectious disease gave public health leaders the incentive to examine and update public health laws.

Oregon Turning Point
From Standards to Practice

The second priority was to develop standards for local and state public health that would be consistent with the nationally recognized Ten Essential Services of Public Health and build on Oregon's existing standards. These two priorities determined Oregon Turning Point's work over the past six years.

Dr. Grant Higginson, Oregon's state health officer, has been an active participant in the Turning Point Public Health Statute Modernization National Excellence Collaborative. When the collaborative developed the Model Emergency Health Powers Act in 2001, Oregon's Turning Point partnership, then directed by Kathryn Broderick, seized the opportunity to use this tool to assess Oregon's emergency health powers. The process began in 2001 and brought together state and local public health leaders, legislators, and other partners to compare Oregon's existing laws with the model act, and to identify improvements needed to make the laws effective in modern crises and emergencies. As a direct result of this effort, the Oregon legislature passed a number of provisions to provide public health the powers needed.

When the Public Health Statute Modernization National Excellence Collaborative developed the Model Emergency Health Powers Act in 2001, Oregon's Turning Point partnership... seized the opportunity to use this tool to assess Oregon's emergency health powers.

Between 2001 and 2003, the Oregon partnership also conducted a joint state/local process to revise the Oregon Minimum Public Health Standards, incorporating standards also based on the Ten Essential Services of Public Health.

Since 2003, Oregon Turning Point has been working with public health consultants, Milne & Associates, LLC, to lead the Oregon Public Health System Assessment project. The consultants convened a broad-based committee to provide oversight for the project. Then the consultants facilitated assessments of system performance in nine representative Oregon counties, using a national public health standards assessment tool. The assessments provided information to each of the nine communities on both strengths and areas to be strengthened through community collaboration. They also generated a great deal of interest in public health among partner organizations. The combined assessment results paint a picture of local public health capacity across the state.

In a follow-up to the 2001-02 work of Turning Point, the second project element consisted of a comprehensive review of all of Oregon's public health statutes and regulations using the Turning Point Model Act for comparison. As a result, legislation may be introduced in the next state legislative session to address areas where problems were found.

Oregon Turning Point's continuing legacy can be seen in updated public health laws, revised Oregon standards, and local public health systems working toward improved practice.

At a Glance: *Oregon*

Aim of Oregon Turning Point

Oregon Turning Point aims to safeguard the public's health by using information to make informed decisions in times of limited resources.

Oregon's Public Health Challenges

Assessments of Oregon's public health system in 2000 and 2002 showed substantial gaps, particularly in the prevention of infectious disease. Despite new funding for bioterrorism responsiveness, gaps continue to exist in public health services. Among vital public health functions, most are performed without adequate resources.

Tobacco use was identified as the leading cause of preventable deaths in Oregon and a voter-approved initiative provided funding over the past five years that led to a dramatic decrease in tobacco use by adults and teenagers. Obesity and cancer are the next leading causes of preventable Oregon deaths.

An assessment of nine local public health systems performed in 2004 identified relative strengths in work related to diagnosis and investigation of health problems, emergency preparedness, and enforcement of public health laws. However, significant shortcomings were found in monitoring health status (particularly regarding information technology capacity) collaboration with community partners, and evaluation of health services.

Oregon Turning Point's Contribution to Improving Public Health

Oregon's public health system provides important services and protections. Coalitions, networks, and clinics have demonstrated that they can come together in partnership with state and other agencies to share information. Oregon Turning Point is helping to improve public health by

- Supporting collaborative partnerships at local and state levels that include hospitals, physicians, nonprofit agencies, county governments, businesses, schools, faith communities, and environmental health organizations
- Completing a review of Oregon's public health statutes and administrative rules, using the Turning Point Model State Public Health Act as a standard
- Developing standards for local and state public health systems to ensure adequate services to all Oregonians
- Convening health-related organizations to identify health policy changes necessary to meet public health demands in Oregon for the future health and safety of Oregonians
- Conducting assessments in nine communities leading to greater awareness of essential service areas that need improvement as well as essential services that are most consistently being provided

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Back in 2001, Morris Govan was a district health officer for six counties in South Carolina looking to improve the public health system. His partnership, the Orangeburg County Health Improvement Coalition, was one of the first community public health coalitions to be developed using Turning Point support. Morris's belief in community engagement and his willingness to be a change agent by applying new tools and processes to the practice of public health, is leading to a genuinely stronger public health system.

South Carolina Turning Point
Leading Through Change

South Carolina's public health system has long been the picture of organizational clarity. Their unified health system means that even local public health workers are state employees, in one hierarchical structure, ultimately answering to one leader. The upside? Throughout the state, personnel and resources can be coordinated efficiently whether for planning or in a crisis. But Morris came around to asking himself and others—is this one-size-fits-all approach to public health serving the needs of various communities? Are we aware of the needs of communities and answering these needs? Morris wanted to try a new way of working that involved grassroots community engagement. When his health district received their Turning Point grant, they had an opportunity to learn what happens when you adopt community engagement processes in public health.

Between 2001 and 2003, the then budding coalition used "Mobilizing for Action Through Planning and Partnership (MAPP)," a NACCHO-developed tool to establish partnerships, identify community themes, and priorities, and develop forces of change. With department staff, Morris developed a broad-based coalition, which then carried out a local public health system assessment to identify weaknesses in the essential services. They gathered data on health and behaviors in Orangeburg, conducting surveys to understand community concerns at PTA meetings, health fairs, schools, grocery stores, gas stations, and in the flu vaccine mobile van. Once the surveys were in, partners analyzed the results and conducted key informant interviews and a satisfaction survey to gain community perspectives of the local health department. The analysis is being used to prioritize areas needing immediate attention. For South Carolina this process of grassroots planning and the resulting priorities and projects are nothing short of revolutionary. For example, as a result of the use of MAPP, the district incorporated and strengthened a new local diabetes coalition to address this chronic disease in the community.

The demonstration project has undoubtedly led to increased attention to *local* public health concerns and improved community involvement in public health, both of which are positive results. Morris and others discovered that community involvement does make the public health system more responsive to the local communities' needs.

Morris is now assistant deputy commissioner of Health Services for SC Department of Health and Environmental Control. He continues in his role as a change agent in public health, encouraging other health directors to use this process to improve community health in their geographic areas. As a critical mass of counties discover its benefits, community engagement is moving from a demonstration project to a policy change. Morris is honing his skills for the next improvement process—studying *Silos to Systems* and instituting a performance management system for South Carolina.

At a Glance: *South Carolina*

Aim of South Carolina Turning Point

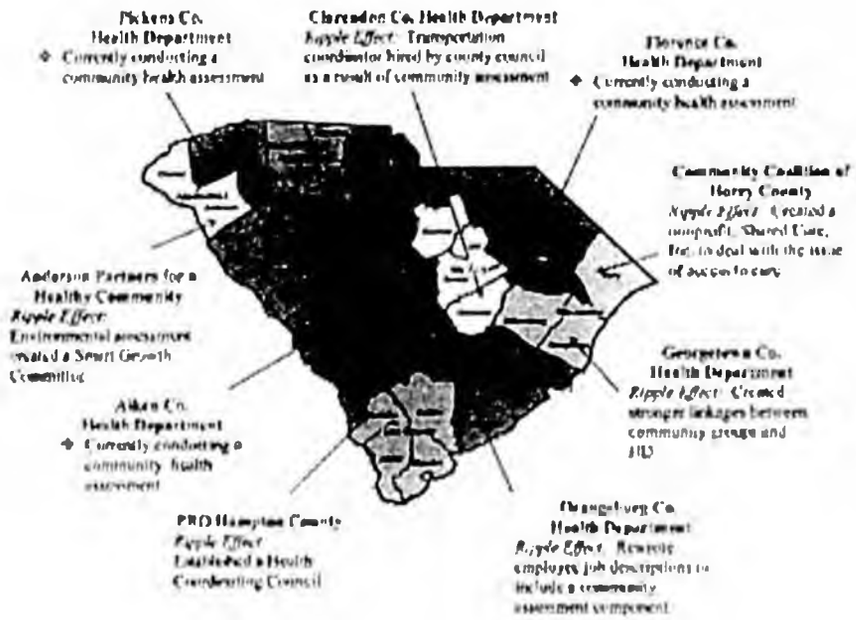
In South Carolina, Turning Point is the institutional embodiment of a new way of doing business in public health, incorporating a diverse group of public, private, state, and local organizations. By using a collaborative process that merges professional expertise, community wisdom, and political will, Turning Point aims to strengthen the state's capacity to protect and improve the public's health.

South Carolina's Public Health Challenges

South Carolina leads the nation in many health indicators from cardiovascular deaths to HIV/AIDS. Particularly troubling are the persistent health disparities between white and African American residents. These indicators and disparities relate to complex community problems associated with lifestyles, the environment, economics, and access to care. State budget cuts, categorical federal funding, and new demands for emergency preparedness are stressing the existing structure of state, district, and county public health offices and limiting their ability to respond to local communities' unique needs.

South Carolina Turning Point's Contribution to Improving Public Health

On the state level, South Carolina Turning Point has led a community-engaged planning and action process, funding three community-based organizations and six local health departments to conduct community health assessments using MAPP. In addition, Turning Point is implementing workforce training programs and encouraging public health leadership in several counties in the state.



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Andy is twelve, and his parents lovingly call him "sturdy," but he is carrying an extra 45 lbs., which makes him clinically obese. Although they live in the beautiful mountains of Appalachia in Wythe County, Virginia, the family doesn't get much exercise, and mom and dad are also overweight. The family doesn't realize they are courting an often preventable disease, type 2 diabetes. Diabetes means a lifetime of constant management of insulin levels, and even when "managed," diabetes carries a high risk of blindness, amputation, and premature death. If Andy's parents knew this, they might make lifestyle changes that could prevent this disease.

Virginia Turning Point

Natural Allies

In Wythe County, the age-adjusted mortality rate of diabetes as primary cause of death is more than twice that of the state rate. As researchers look for reasons for the discrepancy, public health workers are trying to save lives with screening and education. For those at high risk, like Andy and his family, reasons are not as important as outreach and education.

Health department nurses screen for diabetes at health fairs, and the local hospital provides classes for newly diagnosed diabetics referred by physicians. Unfortunately, you won't find Andy's family, or many others who are at risk, at a health fair. In 2001, hospital and health department staff were increasingly frustrated that despite their efforts diabetes hospitalizations and mortality remained high. They needed a new outreach strategy.

...center staff recognized an untapped resource and ally in Wythe County: the business community. Diabetes can mean many work hours lost to illness...diabetes affects a business's bottom line.

In the meantime, the Virginia Center for Healthy Communities in Richmond, an outgrowth of the Virginia Turning Point Initiative, was exploring roles that non-public health partners could play in improving the health of their communities. Constantly on the lookout for natural allies, the Center staff recognized an untapped resource and ally in Wythe County: the business community. Diabetes can mean many work hours lost to illness. Because insurance companies pass the higher costs of caring for the chronically ill on to the group purchasers, diabetes affects a business's bottom line.

In January 2002, the Center's Turning Point director, Jeff Wilson, spoke to the Wytheville-Wythe-Bland Chamber of Commerce. The Chamber's executive board members and executive director Jennifer Jones quickly saw the relationship between preventive health and their interests. The Chamber enthusiastically formed an alliance with public health. Business owners would help reach people by opening their workplaces to health interventions. With the local health department and hospital on point for service delivery, and the Center providing technical assistance, the Chamber is leading a social marketing intervention complete with screenings at worksites, education about lowering diabetes risk, and materials about preventing and managing diabetes. The Chamber's new Health Task Force is considering expanding the program with a physical activity or nutrition intervention.

The Wytheville-Wythe-Bland Chamber of Commerce's Health Task Force brings together business leaders, health educators from the local health department, and nurses from the community hospital. Their combined vision and expertise generates creative solutions to health problems. The Virginia Center for Healthy Communities links sectors and helps each see their distinct role in improving the public's health. By taking the lead and lending their tremendous assets to public health, business leaders in this part of Appalachian Virginia are making a difference for business and Andy's family – a winning outcome for all.

At A Glance: *Virginia*

Virginia Center for Healthy Communities

Aim of Virginia Turning Point

Turning Point's Virginia Center for Healthy Communities is an independent, nonprofit organization dedicated to improving the health of Virginia's communities. The Center bridges the gap between the public health, health care, and business sectors; demonstrates the strong relationship between improved health and economic prosperity; and supports collaborative efforts to improve health. The Center's mission is to support public/private partnerships that improve the health of local communities by conducting research on community health, sharing information with organizations and individuals interested in community health, and providing technical assistance for local community health improvement efforts. The ultimate aim of the Center is a Virginia where each community strives to optimize the health and quality of life for its citizens.

Virginia's Public Health Challenges

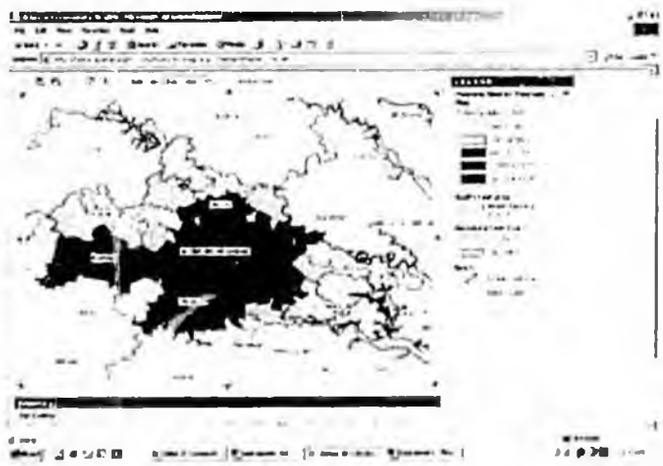
Virginia is respected as a safe and healthy place to live, but troubling signs are ahead. Virginia spends $300 million per year to cover inpatient treatment for preventable injuries. The state loses $2.8 billion annually in direct medical and indirect costs related to diabetes. More than one million Virginians are without basic health insurance. In just the past six years, Virginia's overall health status has fallen from 10th in the nation to 19th.

Virginia Turning Point's Contribution to Improving Public Health

Virginia Turning Point has successfully

- Engaged the business community within the Commonwealth of Virginia in community health improvement activities, such as workplace diabetes screenings and interventions.
- Developed the Virginia Atlas of Community Health, an online publicly available resource providing zip-code level data and maps depicting up to two indicators and capable of running reports on health status in specific areas of the state.
- Conducted three Business Roundtables on Health, opportunities for business leaders to dialogue with public health officials, health care providers, elected officials, and local government personnel about health issues facing their communities.
- Established an independent 501(c)3 called the Virginia Center for Healthy Communities, a self-sustaining organization dedicated to developing effective public-private partnerships reflecting diverse sectors to improve health for Virginians.

Virginia Atlas of Community Health



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On July 10, 2001, West Virginia Turning Point Director, Amy Atkins, was preparing for the next day's First Invitational Roundtable on Public Health Partnerships, dedicated to strengthening the working relationship between state and local public health. As rain lashed the windows and flood waters rose, Amy realized that the Roundtable would have to be cancelled.

West Virginia Turning Point
Watching a System Grow

State and local public health departments, each with their own disaster response procedures, responded to the mounting flood conditions. As part of the Division of Public Health Nursing and Administration at the State Department of Health, Amy and her colleagues were to maintain contact with each local health department (LHD) in the affected areas, assess their needs, and provide assistance. Immediately things started to go wrong.

First, Amy found herself without emergency numbers for some of the LHD staff. In some cases she had to reach them through their neighbors! Then, there was a struggle for tetanus vaccine. Local staff faced crowds of people at their doors demanding tetanus shots and requested additional vaccine. For many it was not medically indicated and state supplies were low. Working relationships between state and local public health were strained. Roles and responsibilities were not clearly defined, efforts were duplicated, and in some cases, no one was assigned to critical tasks.

As the flood waters subsided and the immediate crisis passed, there were many repairs to do, not the least of which was in the public health system. To start with, state and local officials found the rescheduled Invitational Roundtable on Public Health a great opportunity to plan how to improve their emergency response systems while they focused on improving their work relationship in general.

Did their work to improve their relationships and coordinate procedures pay off? Success was crystal clear two years later as Hurricane Isabelle threatened the eastern panhandle of West Virginia. Isabelle's arrival meant potential mass power outages, flooding, and heavy winds. Unlike in the 2001 flood, state and local public health handled the 2003 emergency far more effectively. The disaster network was activated with clear messages for community partners. State Department of Health staff began calling and e-mailing their assigned LHD agencies about specific preparations. The night before Isabelle arrived, the local health departments distributed communications materials to the press, moved vaccines to facilities with backup generator power, and conducted local emergency planning meetings with their partner agencies. Besides the change in communication procedures and strategy, distrust had been replaced with confidence and support. Instead of a state health department and local health departments, a public health system had emerged. Locals had tetanus vaccine available and knew where additional doses could be found. The state had arranged for even more doses to be shipped in from out of state if more was needed beyond what had been given to the local health departments.

The Invitational Roundtable on Public Health Partnerships is now part of a formal planning process between the state and local public health agencies. The principles established through this process serve as the framework for how the parts of the West Virginia public health system work together. These principles do not just live on a shelf. They provide guidance to the organizations as they continue to improve the way public health agencies work together, not just in the area of disaster response but in everyday public health functions.

At a Glance: *West Virginia*

Aim of West Virginia Turning Point

West Virginia Turning Point focuses on improving the performance of and working relationship between state and local governmental public health agencies in order to more effectively address health issues. In addition, they are creating processes that measure the performance and effectiveness of public health activities throughout the state.

West Virginia's Public Health Challenges

West Virginia is the second most rural state in the nation, which increases the importance of strong and coordinated local partnerships. In 1997, 34 of the 49 local health departments in West Virginia were experiencing severe reduction in services and workforce due to a dramatic decrease in revenue and support. In addition, West Virginia's communicable diseases were being underreported and the need to strengthen surveillance capacity had been identified. Perhaps most essential, public health planning efforts have historically lacked a formal process for setting joint short- and long-term priorities.

West Virginia Turning Point's Contribution to improving Public Health

West Virginia Turning Point has:

- Regularly assessed the performance of local public health services through a new accountability structure that ensures West Virginians receive standardized care and ongoing improvements to services that protect their health. A prime example is the use of performance standards and surveillance indicators to reduce the time it takes to recognize a new infectious disease outbreak in West Virginia.
- Convened active partnerships of representatives from a variety of sectors that have a stake in public health at the local level to share resources and decision making based on local priorities.
- Supported community partnerships in developing local policies and revising outdated public health codes.
- Strengthened the relationship between state and local public health through formal working agreements and joint planning and assessment.
- Increased the capability of the public health workforce through the development of standardized job descriptions, orientation programs, and structured training tools for public health staff.
- Improved public health's ability to track emerging infectious diseases by developing performance standards, increasing regional and state staff, strengthening laboratory capacity, and providing quarterly trainings.

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Consider: "There is nothing more difficult to take in hand, more serious to conduct, or more uncertain in success than to take the lead in the introduction of a new order of things, because the innovator has for enemies all who did well under the old conditions, and only lukewarm defenders of those who may do well in the new" (Machiavelli, 1505)

Wisconsin Turning Point
Social Change in Action

This fear —*lukewarm defenders of those who may do well in the new*— was one of several transformation obstacles identified by a small group of innovators in 1998. They were told they were "overtaken by madness" and instead of transforming the public health system they were on a course to destroy it. Consider some of the obstacles they faced. Although people cared about "public health," they lacked common agreement on basic definitions. They lacked a compelling set of statewide priorities. Policies, programs, and ways of thinking impeded change. Partnerships were needed yet trust was lacking. The focus was on programs rather than on the system.

The public health system was viewed as the "country cousin" to health care. No matter how hard and how effective they were, the label stuck. Policy leaders viewed public health as a program— not as a system. They viewed its priorities as "everything but the kitchen sink." "Balkanized information systems" impeded health status evaluation. Tall order of challenges? You bet! But they had hope, idealism, courage, and opportunity. They didn't have a model so they built one with their partners.

The Turning Point Initiative is Wisconsin's statewide policy process for change. It has produced a legislatively mandated state health plan (and implementation plan), *Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public*. The Initiative's work is grounded in science, strategic planning, quality assurance, and collaborative partnerships. It inspires a collective consciousness that it takes the work of many to improve the health for all.

The Initiative has brought policy, data, partners, process, and measurement into alignment. It directly links *Healthiest Wisconsin 2010* to the department's Strategic Plan. It created a framework— a transformational pathway— that depicts the vision, core functions, essential services, goals, priorities, and desired outcomes (1) improve the health of the public, and (2) improve public health system capacity.

And the results? Now the department and its partners align their work and federal grants to the framework's essential services, goals, and priorities. Many of the partners own *Healthiest Wisconsin 2010* as their own plan. Local health departments have linked local priorities to the statewide priorities. An external community governance structure was formed to monitor implementation and champion transformation. And finally, Wisconsin's two conversion foundations have formally gone on record to award 35 percent of the total resources to communities who link their grant applications to the priorities of *Healthiest Wisconsin 2010*.

At a Glance: *Wisconsin*

Aim of Wisconsin Turning Point

Wisconsin Turning Point reflects a transformation in the way Wisconsin operates its public health system and addresses its priorities. Maintaining the health of the public was once solely identified as a governmental responsibility, but Turning Point in Wisconsin aims to define more broadly the roles and responsibilities for improving the health of Wisconsin communities and its 5.4 million residents.

Wisconsin's Public Health Challenges

Poor access to health services, inadequate nutrition, exposure to environmental hazards, emerging infectious diseases, and other issues are priority areas for intervention if Wisconsin's public health leaders are to improve the health of Wisconsin residents. Wisconsin's public health system must be restructured to eliminate health disparities and protect and promote the health of all. No one sector can maximize improvements in the health of Wisconsin residents; multi-sector partnerships focused on health promotion and disease prevention are crucial for success.

Wisconsin Turning Point's Contribution to Improving Public Health

Wisconsin Turning Point led the development of *Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public*. This strategic health plan focuses on health promotion, disease prevention, and building a strong public health system with the partners. Wisconsin Turning Point is also:

- Developing policy recommendations to improve public health laws that provide legal support for the protection of Wisconsin residents
- Ensuring good management of resources through quality assurance activities with public health partners
- Creating model practices, such as award-winning, countywide coalitions for early childhood immunization
- Facilitating innovative state, federal, and private partnerships to solve access issues and other public health challenges
- Expanding academic/community partnerships to advance health throughout the state

Wisconsin Turning Point's Unique Transformational Framework Includes

- A shared vision of Wisconsin's public health system (shared by all partners)
- Core principles and values (social justice, common good, and creating positive futures for all)
- Establishing five infrastructure priorities as the "engine" for collective action by the partners
- Overarching goals of eliminating health disparities, promoting and protecting health for all, and transforming Wisconsin's public health system

For More Information

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Page 6: Alaskan children, photo by Elfrieda Nord

Page 9: AZHealthInfo.org Web site

Page 11: Diabetes statistics, from Profile of Health Disparities among Communities of Color, ColoradoTurning Point, 2001

Page 12: Illinois State Capitol

Page 14: Kim Kimminau, of Kansas Turning Point, teaching a data class to community health program representatives.

Page 16: Terri Gremillion, Community Encourager for Avoyelles Parish, Louisiana, giving a community presentation.

Page 18: Governor John Baldacci of Maine at Maine Network of Healthy Communities event at the State Capitol Hall of Flags.

Page 20: Kristin with Minnesota Turning Point's Emerging Leaders Network Class of 2003.

Page 26: Nebraska public health worker, Barb Pacsett participating in the NIIHSS Disaster Response Command and Control Drill at the Receiving, Staging and Storing Site

Page 30: New Hampshire public health nurses during hepatitis A outbreak

Page 32: Studio picture during filming of Dr. Kristine Gebbie, T2B2 guest, and moderator Joiel Ray-Alexander, on New York Turning Point's Third Thursday Breakfast Broadcast.

Page 34: North Carolina Senator Fletcher Hartsell and Linda Attarian reviewing North Carolina public health law.

Page 36: Oklahoma police enforcing seatbelt ordinance

Page 40: Morris Govan, of South Carolina Turning Point, with district health officers Harvey Kayman and Bedy Campbell.

Page 42: Virginia Atlas of Community Health Web site

Page 44: Public health nurse administering tetanus vaccine in West Virginia, photo by Kay Shamblin

Page 46: Wisconsin Turning Point partners share their innovative public health framework with 25 physician representatives from five Russian-speaking countries.